**Australian Government**
**Department of Health and Ageing**

# Medicare Benefits Schedule Book

# Category 3

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

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

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### G.1.1. THE MEDICARE BENEFITS SCHEDULE - INTRODUCTION

**Schedules of Services**
Each professional service contained in the 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.

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

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

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

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

### G.1.2. MEDICARE - AN OUTLINE

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

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

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

- i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
- ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or 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, Medicare Australia may request its return from the practitioner concerned.

### G.1.3. MEDICARE BENEFITS AND BILLING PRACTICES

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

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

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

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

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

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

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

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

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

### G.2.1. PROVIDER ELIGIBILITY FOR MEDICARE

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

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

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

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

**Non-medical practitioners**
To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-88000 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 Medicare Australia to provide these services.

### G.2.2. PROVIDER NUMBERS

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

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

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

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

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

### G.2.3. LOCUM TENENS

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

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

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

### G.2.4. OVERSEAS TRAINED DOCTOR

**Ten year moratorium**

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

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

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

| | | |
|---|---|---|
| **NEW SOUTH WALES**<br>Medicare Australia Paramatta Office<br>130 George Street<br>PARRAMATTA NSW 2150 | **VICTORIA**<br>Medicare Australia Melbourne Office<br>Level 10<br>595 Collins Street<br>MELBOURNE VIC 3000 | **QUEENSLAND**<br>Medicare Australia Brisbane Office<br>143 Turbot Street<br>BRISBANE QLD 4000 |
| **SOUTH AUSTRALIA**<br>Medicare Australia Adelaide Office<br>209 Greenhill Road<br>EASTWOOD SA 5063 | **WESTERN AUSTRALIA**<br>Medicare Australia Perth Office<br>Level 4<br>130 Stirling Street<br>PERTH WA 6003 | **TASMANIA**<br>Medicare Australia Hobart Office<br>199 Collins Street<br>HOBART TAS 7000 |
| **NORTHERN TERRITORY**<br>As per South Australia | **AUSTRALIAN CAPITAL TERRITORY**<br>Medicare Australia National Office<br>134 Reed Street North<br>GREENWAY ACT 2901 | |

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

Provider Enquiries: 132 150
Public Enquiries: 132 011

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

### G.3.1. PATIENT ELIGIBILITY FOR MEDICARE

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

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

### G.3.2. MEDICARE CARDS

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

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

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

### G.3.3. VISITORS TO AUSTRALIA AND TEMPORARY RESIDENTS

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

### G.3.4. RECIPROCAL HEALTH CARE AGREEMENTS

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

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 Medicare Australia 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.

### G.4.1. GENERAL PRACTICE

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

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

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

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

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

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

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

**Vocational recognition of general practitioners**

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

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

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

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

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

Further information on eligibility for recognition should be directed to:

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

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

Executive Assistant, ACRRM:

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

***How to apply for vocational recognition***

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

Chief Executive Officer
The Royal Australian College of General Practitioners
100 Wellington Parade,
EAST MELBOURNE VIC 3002

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

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

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

Continued vocational recognition is dependent upon:

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

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

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

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

***Removal of vocational recognition status***

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

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

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

### G.5.1. Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

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

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

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

### G.5.2. EMERGENCY MEDICINE

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

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

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

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

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

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

**What is a Referral?**

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

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

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

The exceptions to the requirements in paragraph above are that

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

(b) sub-paragraphs (ii) and (iii) do not apply to
- a referral generated during an episode of hospital treatment, for a 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 not a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

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

**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 18 months from the date the service was rendered.

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

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

**Locum-tenens Arrangements**
It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the

level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

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

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

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

### G.7.1. BILLING PROCEDURES

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

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

i. patient's name;
ii. the date the professional service was rendered;
iii. the amount charged for the service;
iv. the total amount paid in respect of the service;
v. any amount outstanding in respect of the service;
vi. for professional services rendered to a patient as part of an episode of hospital treatment; an asterisk '*' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the words 'admitted patient' ;
vii. for professional services rendered as part of a privately insured episode of hospital-substitute treatment and the patient who receives the treatment chooses to receive a benefit from a private health insurer, the words ‘hospital-substitute treatment’ directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the words ‘hospital-substitute treatment’;
viii. the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with Medicare Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given);
ix. the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-
    a. for services in Groups A1 to A14, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillofacial services), and Group P9 of Pathology - where the person claiming payment is NOT the person who rendered the service;
    b. for services in Groups D2, T2, T3, I2, to I5 - for every service;
x. if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;
xi. where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and
xii. where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number for that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under these arrangements:-

- the patient's Medicare number must be quoted on all direct-bill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;

- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;

Where a patient is unable to sign the assignment form:

- the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable; or
- In the absence of a "responsible person" the patient signature section should be left blank.

Where the signature space is either left blank or another person signs on the patient's behalf, the form **must** include:

- the notation “Patient unable to sign” and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Where the patient is direct-billed, an additional charge can **ONLY** be raised against the patient by the practitioner where the patient is provided with a vaccine/vaccines from the practitioner’s own supply held on the practitioner’s premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items 3 to 96 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.

**Use of Medicare Cards in Direct Billing**

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

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

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

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

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

**Assignment of Benefit Forms**

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

1. Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.
2. Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.
3. Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.

4. Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.
5. Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.
6. Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by Medicare Australia for that purpose.

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

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

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

**Direct-Bill Stationery (Forms DB6Ba & DB6Bb)**
Medical practitioners wishing to direct-bill may obtain information on direct-bill stationery by telephoning 132150.

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

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

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

### G.8.1. PROVISION FOR REVIEW OF INDIVIDUAL HEALTH PROFESSIONALS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### G.8.2. MEDICARE PARTICIPATION REVIEW COMMITTEE

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

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

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

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

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

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

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

### G.8.4. 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.

### G.8.5. MEDICAL SERVICES ADVISORY COMMITTEE

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

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

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

### G.8.6. PATHOLOGY SERVICES TABLE COMMITTEE

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

### G.8.7. MEDICARE CLAIMS REVIEW PANEL

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

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

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

Applications for approval should be addressed to:
**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

### G.9.1. PENALTIES AND LIABILITIES

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

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

### G.10.1. SCHEDULE FEES AND MEDICARE BENEFITS

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

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

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

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

There are presently three levels of Medicare benefit payable:

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

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

(c) **85% of the Schedule fee,** or the Schedule fee less $74.50 (indexed annually), 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.

### G.10.2. 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 2013 is $421.70. 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 2013, 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 $610.70. The threshold for all other singles and families is $1,221.90.

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

Individuals are automatically registered with Medicare Australia 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 Medicare Australia offices, or completed online at www.medicareaustralia.gov.au.

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:

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

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

### G.11.1. SERVICES NOT LISTED IN THE MBS

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

Enquiries about services not listed or on matters of interpretation should be directed to Medicare Australia on 132 150.

### G.11.2. MINISTERIAL DETERMINATIONS

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

### G.12.1. PROFESSIONAL SERVICES

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

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

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);
(d) Item 15600 in Group T2 (Radiation Oncology);
(e) All Group T3 (Therapeutic Nuclear Medicine) items;
(f) All Group T4 (Obstetrics) items (except 16400 and 16514);
(g) All Group T6 (Anaesthetics) items;
(h) All Group T7 (Regional or Field Nerve Block) items;
(i) All Group T8 (Operations) items;
(j) All Group T9 (Assistance at Operations) items;
(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

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

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

### G.12.2. SERVICES RENDERED ON BEHALF OF MEDICAL PRACTITIONERS

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

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

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

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

### G.12.3. MASS IMMUNISATION

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

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

### G.13.1. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

**Services not attracting benefits**

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

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

- are paid/payable to a public hospital;
- are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);
- are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- are incurred in mass immunisation (see General Explanatory Note 12 for further explanation).

**Unless the Minister otherwise directs**

Medicare benefits are not payable where:

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

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

(a) Endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;
(b) Gamma knife surgery;
(c) Intradiscal electro thermal arthroplasty;
(d) Intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
(e) Intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
(f) Low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
(g) Lung volume reduction surgery, for advanced emphysema;

(h) Photodynamic therapy, for skin and mucosal cancer;
(i) Placement of artificial bowel sphincters, in the management of faecal incontinence;
(j) Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
(k) Specific mass measurement of bone alkaline phosphatase;
(l) Transmyocardial laser revascularisation;
(m) Vertebral axial decompression therapy, for chronic back pain.
(n) Autologous Chondrocyte Implantation and Matrix-induced Autologous Chondrocyte Implantation.
(o) Vertebroplasty

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

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

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

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

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

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

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

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

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

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

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

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

### G.14.1. PRINCIPLES OF INTERPRETATION OF THE MBS

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

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

### G.14.2. SERVICES ATTRACTING BENEFITS ON AN ATTENDANCE BASIS

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

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

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

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

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

### G.14.4. AGGREGATE ITEMS

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

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

### G.14.5. RESIDENTIAL AGED CARE FACILITY

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

### G.15.1. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS

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

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

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

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

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

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

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

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

# THERAPEUTIC PROCEDURES
# CATEGORY 3

# SUMMARY OF CHANGES FROM 1/05/2013

The 1/05/2013 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number

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

## New items from 1/05/2013

32523 32526

## Amended Descriptions from 1/05/2013

32520 32522 37201 37202 37203 37206 37207 37208 37245

## EMSN Changes from 1/05/2013

32523 32526

### T.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.

### T.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.

### T.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.

### T.1.4. ASSISTED REPRODUCTIVE TECHNOLOGY ART SERVICES - (ITEMS 13200 TO 13221)

From 1 January 2010, the Medicare items for ART services, including In-Vitro Fertilisation (IVF), have been restructured in consultation with the ART profession and the patient group ACCESS. The new structure better reflects current clinical practice and will help to spread the cost of EMSN caps across the treatment cycle. For further information on the changes to the EMSN see the fact sheet under Latest News on MBS Online.

There are no restrictions on the number of cycles that patients can have nor are there any age restrictions for these items.

The new structure includes two new items (13201 and 13202) and a number of amended items. Item 13200 has been amended and will provide for an **initial** treatment cycle in a single calendar year. New item 13201 has been introduced for a **subsequent** treatment cycle in association with items 13200 and 13202. New item 13202 covers an incomplete stimulated cycle, and can be billed as an initial treatment cycle in a single calendar year.

Embryology laboratory services covered by Items 13200, 13201 and 13206 have been amended to include the preparation of sperm together with egg recovery from aspirated follicular fluid, insemination, monitoring of fertilisation and embryo development, and preparation of gametes or embryos for transfer and freezing.
Items 13200, 13201, 13202, 13206, 13215 and 13218, do not include services provided in relation to artificial insemination.

Item 13221 has been amended to exclude sperm preparation for assisted reproductive technology using IVF. This item now provides for the preparation of sperm for the purpose of artificial insemination and can only be rendered in conjunction with item 13203.

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 conjunction with items 13200 – 13221 but excluding item 13202. 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 not more than 30 days later.

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 Medicare Australia 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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.1.14. PUVA OR UVB THERAPY - (ITEMS 14050 AND 14053)

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

### T.1.15. LASER PHOTOCOAGULATION - (ITEMS 14106 TO 14124)

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 $cm^2$ |

### T.1.16. LASER PHOTOCOAGULATION (ITEM 14124)

Item 14124 applies where additional treatments are indicated in a 12 month period and are only claimable for haemangiomas of infancy.

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

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

Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 1001**
**Tuggeranong ACT 2901**

### T.1.17. 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.

### T.1.18. HORMONE AND LIVING TISSUE IMPLANTATION - (ITEMS 14203 AND 14206)

Items 14203 and 14206 are not payable for artificial insemination.

### T.1.19. 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.

### T.1.20. IMMUNOMODULATING AGENT - (ITEM 14245)

Item 14245 applies only to a service provided by a medical practitioner who is registered by the Medicare Australia 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.

### T.1.21. 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.

### T.1.22. 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 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.

From 1 January 2013, six new MBS item numbers (113, 114, 384, 2799, 3003 and 6004) are introduced to 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 new items are stand alone items and will 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*
From 1 January 2013, geographic eligibility for telehealth services funded under Medicare will be determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. A Telehealth Eligible Area will be those areas that are outside a Major City (RA1) according to ASGC-RA. Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

From 1 November 2012, 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 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.

### T.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.

### T.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.

### T.2.3. PLANNING SERVICES - (ITEMS 15500 TO 15562 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 (inclusive) are for a planning episode for 3D conformal radiotherapy.

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.

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

### T.2.4. TREATMENT VERIFICATION - (ITEMS 15700 TO 15705, 15710 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 and 15710:

- 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.

### T.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).

### T.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 Medicare Australia 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.

### T.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.

### T.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, 16504, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514 and 16600 to 16636.
(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 16504 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

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 delivery.

### T.4.4. EXTERNAL CEPHALIC VERSION FOR BREECH PRESENTATION - (ITEM 16501)

Contraindications for this item are as follows:
- antepartum haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- intrauterine growth retardation (IUGR),
- caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- premature rupture of the membranes.

### T.4.5. LABOUR AND DELIVERY - (ITEMS 16515, 16518, 16519 AND 16525)

Benefits for management of labour and delivery covered by Items 16515, 16518, 16519 and 16525 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 delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then 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.

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

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 delivery) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and delivery, 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 delivery benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the delivery) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk deliveries include cases of difficult vaginal delivery, Caesarean section or the delivery of babies with Rh problems and babies of toxaemic mothers.

### T.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 delivery 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.

### T.4.7. COMPLICATED CONFINEMENT - (ITEM 16522)

Conditions that pose a significant risk of maternal death referred to in Item 16522 include:
- severe pre-eclampsia as defined in the Consensus Statement on the Management of Hypertension in Pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
- cardiac disease (co-managed with a consultant physician or a specialist physician);
- coagulopathy;
- severe autoimmune disease;
- previous organ transplant; or

- pre-existing renal or hepatic failure.

### T.4.8. LABOUR AND DELIVERY WHERE CARE IS TRANSFERRED BY A PARTICIPATING MIDWIFE - (ITEMS 16527 TO 16528)

Where the inter-partum care of a women is transferred to a medical practitioner by a participating midwife for 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.

### T.4.9. ITEMS FOR PLANNING AND MANAGEMENT OF A PREGNANCY (ITEM 16590)

Item 16590 is intended to provide for the planning and management of pregnancy that has progressed beyond 20 weeks, where the medical practitioner is intending to undertake the delivery for a privately admitted patient. From 1 January 2010 a new item, 16591, has been introduced to reflect the different responsibilities of GPs and obstetricians who plan to manage the pregnancy, labour and birth, and those who are part of a shared care arrangement. Medical practitioners who do not plan to undertake the delivery of a privately admitted patient should claim item 16591. Both 16590 and 16591 are subject to Extended Medicare Safety Net caps and should only be claimed by a patient once per pregnancy.

### T.4.10. POST-PARTUM CARE - (ITEMS 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 <u>while in labour</u> 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 delivery;
(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 delivery. 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.

### T.4.11. INTERVENTIONAL TECHNIQUES - (ITEMS 16600 TO 16636)

For Items 16600 to 16636, 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, 16627 and 16633.

### T.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 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.

From 1 January 2013, six new MBS item numbers (113, 114, 384, 2799, 3003 and 6004) are introduced to 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 new items are stand alone items and will 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*
From 1 January 2013, geographic eligibility for telehealth services funded under Medicare will be determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. A Telehealth Eligible Area will be those areas that are outside a Major City (RA1) according to ASGC-RA. Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

From 1 November 2012, 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 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.

### T.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.

### T.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.
- 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.

### T.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.

### T.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 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.

From 1 January 2013, six new MBS item numbers (113, 114, 384, 2799, 3003 and 6004) are introduced to 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 new items are stand alone items and will 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*
From 1 January 2013, geographic eligibility for telehealth services funded under Medicare will be determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. A Telehealth Eligible Area will be those areas that are outside a Major City (RA1) according to ASGC-RA. Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

From 1 November 2012, 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 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.

### T.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.

### T.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.

### T.7.3. INTRATHECAL OR EPIDURAL INJECTION - (ITEM 18232)

This items covers caudal infusion/injection.

### T.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, benefits would be payable under item 18219.

### T.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 items 18354, 18356, or 18358 for a dynamic foot deformity.

### T.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.

### T.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%).

### T.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.

### T.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 practitioners, 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.

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. If however, a surgeon delegates aftercare to a patient’s medical practitioner, then a Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the aftercare. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

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.

### T.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 full clinical details of the circumstances of the operation, including details of the surgery proposed and the reasons for the operation being discontinued.

### T.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.

### T.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 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 can be claimed.

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

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

### T.8.8. LIPECTOMY - (ITEMS 30165 TO 30177)

Multiple lipectomies, e.g., both buttocks and both thighs attract benefits under Item 30171 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction, except in the circumstances outlined in Items 45584 and 45585.

Lipectomy items 30165 and 30177 may not be claimed for patients if performed within 12 months after the most recent pregnancy.

Lipectomy items 30165 to 30177 cannot be claimed in association with items 45564, 45565 or 45530. Where the abdomen requires closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565) or breast reconstruction (45530), item 45569 is to be claimed.

### T.8.9. TREATMENT OF KERATOSES, WARTS ETC (ITEMS 30185, 30186, 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. Where one or more solar keratoses are treated by electrosurgical destruction, simple curettage or shave excision, benefits are payable under item 30195.

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) definitive removal of palmar or plantar warts is undertaken. In these circumstances, where less than 10 palmar or plantar warts are treated, by methods other than ablative techniques alone, benefits are paid under item 30186, with fees progressively reducing as for multi operations, and where 10 or more palmar or plantar warts are treated, by methods other than ablative techniques alone, benefits are paid as a flat fee under item 30185.

(d) 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.

Ablative techniques include cryotherapy and chemical removal.

### T.8.10. CRYOTHERAPY AND SERIAL CURETTAGE EXCISION - (ITEMS 30196 TO 30203)

In items 30196 and 30197, 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 to 30203 (inclusive), 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 to 30203 (inclusive), 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.

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

### T.8.11. TELANGIECTASES OR STARBURST VESSELS - (ITEMS 30213 AND 30214)

These items are restricted to treatment on the head and/or neck. A session of less than 20 minutes duration attracts benefits on an attendance basis.

Item 30213 is restricted to a maximum of 6 sessions in a 12 month period. Where additional treatments are indicated in that period, item 30214 should be used.

Claims for benefits under item 30214 should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered.

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

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

Applications for approval should be addressed in a sealed envelope marked ‘Medical-in Confidence’ to:

**The MCRP Officer**
**PO Box 9822**

**SYDNEY NSW 2001**

### T.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.

### T.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.

### T.8.14. LAPAROTOMY AND OTHER PROCEDURES ON THE ABDOMINAL VISCERA - (ITEM 30375)

Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Item 30375 covers several operations on abdominal viscera not dissimilar in time and complexity. Where more than one of the procedures are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

### T.8.15. DIAGNOSTIC LAPAROSCOPY - (ITEM 30390)

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.

### T.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.

### T.8.17. GASTROINTESTINAL ENDOSCOPIC PROCEDURES - (ITEMS 30473 TO 30481, 30484 TO 30487, 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 and Endoscopy (3rd edition), Gastroenterological Society of Australia;
ii. Australian Guidelines for the Prevention and Control of Infection in Healthcare (NHMRC, 2010);
iii. Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

**Anaesthetic and resuscitation equipment**

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post-operative and resuscitation facilities should conform to the standards outlined in '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.

### T.8.18. Revision of Gastric Reduction, Gastroplasty or Bypass - (Item 30514)

Revision of gastric procedure, for example to correct misplacement of the gastric band or other adverse effects of the initial surgery, involves complete reversal of the initial surgery immediately followed by another reduction, gastroplasty or bypass procedure. For revision item 30514 can be claimed with either item 30511 or 30512, whichever is relevant. For cases where division of adhesions exceeds 45 minutes either item 30378 (laparotomy) or item 30393 (laparoscopy) can also be claimed.

### T.8.19. 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.

### T.8.20. 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).

### T.8.21. 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.

### T.8.22. 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).

### T.8.23. Removal of Skin Lesions - (Items 31200 to 31355)

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 31200 to 31240.

The excision of suspicious pigmented lesions for diagnostic purposes attract benefits under items 31205 to 31240. Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.

Items 31200 and 31245 *do not require* the specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that the specimen be sent for histological examination. Items 31255 to 31335 *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 31205 to 31240 should be used. Malignant tumours are covered by items 31255 to 31355.

A practitioner providing the first treatment episode for a primary BCC/SCC must use the appropriate item from the following: 31255; 31260; 31265; 31270; 31275; 31280; 31285; or 31290.

Where residual BCC/SCC remains following an initial excision of a primary lesion and the same practitioner is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31256; 31261; 31266; 31271; 31276; 31281; 31286 or 31291.

Where residual BCC/SCC remains following an initial excision of a primary lesion and a practitioner other than the practitioner that performed the previous excision is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31257; 31262; 31267; 31272; 31277; 31282; 31287 or 31292.

Where a BCC/SCC was removed and complete excision of the lesion was confirmed, but a BCC/SCC has recurred at the primary site, then the items providing for recurrent BCC/SCC would usually apply.

A practitioner excising a recurrent BCC/SCC of the head or neck and who is a specialist in the practice of his or her specialty or a practitioner other than the practitioner who provided previous treatment (where the lesion was removed by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy) must use item 31295.

A practitioner excising a recurrent BCC/SCC from an area other than the head or neck or who otherwise does not meet the criteria as described under item 31295 must use the appropriate item from the following 31258; 31263; 31268; 31273; 31278; 31283; 31288 or 31293.

For the purpose of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. The relevant size of the lesion relates to that measured in situ before excision. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.

Definitive surgical excision for items 31300 to 31335 is defined as "surgical removal with an adequate margin and, as a result, no further surgery is indicated at that site of excision.

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

Items 31245 and 31250 do not cover shave excision.

### T.8.24. REMOVAL OF SKIN LESION FROM FACE - (ITEMS 31235 TO 31245, 31265 TO 31278, 31310 TO 31320)

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

### T.8.25. DISSECTION OF LYMPH NODES OF NECK - (ITEMS 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.

### T.8.26. 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.

### T.8.27. SUBCUTANEOUS MASTECTOMY - (ITEMS 31521, 31524 AND 31527)

When, after completing a subcutaneous mastectomy a prosthesis is inserted, benefits are payable for the latter procedure under Item 45527, the multiple operation formula applying.

Claims for benefits under item 45585 are not payable in association with 31521 or 31527.

### T.8.28. 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.

### T.8.29. 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 Medicare Australia 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.

### T.8.30. 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 Medicare Australia notified of their eligibility to perform this procedure.

### T.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.

### T.8.32. VARICOSE VEINS - (ITEMS 32500 TO 32517)

Claims for benefits under item 32501should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services.

Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with the Department of Human Services for referral to the National Office of the Department of Human Services for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to the Department of Human Services for prospective approval for proposed surgery.

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence' to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

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 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.

### T.8.33. Endovenous Laser Therapy (Items 32520 and 32522) and Radiofrequency Ablation (Items 32523 and 32526)

It is recommended that the medical practitioner performing 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 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.

### T.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 Medicare Australia.

### T.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.

### T.8.36. Arterial and Venous Patches - (Items 33545 to 33551and 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.

### T.8.37. CAROTID PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY WITH STENTING - (ITEM 35307)

This item is introduced into the Schedule following a recommendation of the Medical Services Advisory Committee (MSAC). MSAC recommended that "CPTAS should be funded for patients who meet the criteria for CEA (carotid endarterectomy) but are unfit for open surgery (CEA)." A continuing review of the item usage will be undertaken.

The indications for CEA are: >50% stenosis of carotid artery associated with stroke or transient ischaemic attack; or, >80% asymptomatic carotid stenosis. Medical comorbidities which would be considered to make patients at high risk of anaesthetic perioperative complications at open CEA are: significant coronary artery disease; severe heart failure; severe pulmonary disease; or, age greater than 80 years. Surgical conditions which would make patients unfit for open surgery are: recurrent stenosis post CEA; high cervical internal carotid lesion (above C2); low common carotid lesion below the clavicle; contralateral carotid occlusion; contralateral laryngeal nerve palsy; tracheostomy; or, prior radiation therapy of the neck or neck dissection.

### T.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.

### T.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.

### T.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.

### T.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.

### T.8.42. COLPOSCOPIC EXAMINATION - (ITEM 35614)

It should be noted that colposcopic examination (screening) of women during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:- (i) where the patient has had an abnormal cervical smear; (ii) where there is a history of ingestion of oestrogen by the patient's mother during her pregnancy; or (iii) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

### T.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.

### T.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.

### T.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.

### T.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 by-product 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*.

### T.8.47. DEBULKING OF UTERUS - (ITEM 35658)

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

### T.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.

### T.8.49. SACRAL NERVE STIMULATION - (ITEMS 36658, 36660, AND 36662)

Items 36658, 36660, and 36662 only apply in the following circumstances:

(a) the patients has received a sacral nerve stimulation implant for the management of refractory urinary incontinence or urge retention;

(b) the patient requires replacement or removal of the pulse generator and/or leads for the neurostimulator device; and

(c) the service referred to in paragraph (a) was rendered to the patient prior to 30 April 1998 and a Medicare benefit was paid for that service under item 30000, 39134, 39139 or 39140.

### T.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.

### T.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).

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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).

### T.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).

### T.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 Medicare Australia to process the claims.

### T.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.

### T.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 Medicare Australia notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.8.73. MEATOPLASTY - (ITEM 41515)

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

### T.8.74. Reconstruction of Auditory Canal - (Item 41524)

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

### T.8.75. Removal of Nasal Polyp or Polypi - (Items 41662, 41665 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 Items 41665/41668, benefit for removal of polypi would be paid under Items 41665/41668.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.8.82. Cyclodestructive Procedures - (Items 42770)

Item 42770 is restricted to a maximum of 2 treatments in a 2 year period.

### T.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.

### T.8.84. Laser Trabeculoplasty - (Items 42782 and 42783)

Item 42782 is restricted to a maximum of 4 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42783 should be utilised.

Claims for benefits for item 42783 should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient

clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

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

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence' to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

### T.8.85. LASER IRIDOTOMY - (ITEMS 42785 AND 42786)

Item 42785 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42786 should be utilised.

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

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

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**PO Box 9822**
**SYDNEY NSW 2001**

### T.8.86. LASER CAPSULOTOMY - (ITEMS 42788 AND 42789)

Item 42788 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42789 should be utilised.

Claims for benefits for item 42789 should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

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

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**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

### T.8.87. LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - (ITEMS 42791 AND 42792)

Item 42791 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42792 should be utilised.

Claims for benefits for item 42792 should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

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

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**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

### T.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.

### T.8.89. LASER COAGULATION OF CORNEAL OR SCLERAL BLOOD VESSELS - (ITEM 42797)

Benefits under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.

Benefits are not payable under Item 42797 for procedures undertaken for cosmetic purposes (see paragraph 13.1.2 of the General Explanatory Notes).

### T.8.90. 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.

### T.8.91. FULL FACE CHEMICAL PEEL - (ITEMS 45019 AND 45020)

These items relate to full face chemical peel in the circumstances outlined in the item descriptors. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to confirm that the conditions for payment of benefits have been met. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

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

Applications for approval should be addressed in a sealed envelope marked 'Medical-in Confidence'to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

### T.8.92. 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.

### T.8.93. FOREIGN IMPLANT - (ITEM 45051)

For Medicare benefits to be payable for this item the intention of the implantation must be either to reconstruct facial or body contours which have been damaged by trauma or disease or to correct a deformity which has been pathologically caused.

### T.8.94. 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.

### T.8.95. 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 Items 45200, 45203 or 45206 once only.

Items where benefit for local skin flap repair (if indicated as above) is payable, include:

30023, 30180, 30186, 30269, 31205-31340, 45030, 45033, 45036-45045, 45506, 45512, 45626.

Note: This list is not all-inclusive and there are circumstances where other services might involve flap repair.

The following items are examples of where local flap repair would usually not be payable. If further advice is required, Medicare Australia should be contacted.

30026-30052, 30099-30114, 30165-30177, 31200, 45520, 45522, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

### T.8.96. FREE GRAFTING TO BURNS - (ITEMS 45406 TO 45418)

Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

### T.8.97. 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 31200 to 31240 should be claimed.

### T.8.98. AUGMENTATION MAMMAPLASTY - (ITEMS 45524, 45527 AND 45528)

Medicare benefit is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast some time 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. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked 'Medical-in-Confidence'.

Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

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

### T.8.99. 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, 30168, 30171, 30174 or 30177 (lipectomy items) should not be claimed in association with item 45530 as stated in the *Health Insurance (General Medical Services Table) Regulations*.

### T.8.100. BREAST PROSTHESIS, REMOVAL AND REPLACEMENT OF - (ITEMS 45552 TO 45555)

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 45552-45555 where the procedure is performed solely to increase breast size.

### T.8.101. BREAST PTOSIS - (ITEMS 45556 TO 45559)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, 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.

Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove.

Claims for benefits for items 45557, 45558 and 45559 should be accompanied by full clinical details including colour photographs including an anterolateral view. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. These items are payable only once per patient.

Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

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

### T.8.102. 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.

### T.8.103. LIPOSUCTION - (ITEMS 45584, 45585 AND 45586)

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-Simon's Syndrome (pathological lipodystrophy of hips, buttocks, thighs, and knees or lower legs), lymphoedema or macrodystrophia lipomatosa item 45585 applies.

Claims for benefits under items 45585 and 45586 should be accompanied by full clinical details, including pre-operative colour photographs.

Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in-Confidence'.
Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

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

### T.8.104. MELOPLASTY FOR CORRECTION OF FACIAL ASYMMETRY - (ITEMS 45587 AND 45588)

Benefits are payable under items 45587 and 45588 for face-lift operations performed to correct soft tissue abnormalities of the face due to causes other than the ageing process.

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. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'.

Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

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

For the purpose of items 45587 and 45588 severe acne scarring is defined as scarring on the face or cheeks that is obvious from a distance of 2 metres.

### T.8.105. 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. Where there is doubt as to whether benefits would be payable, advice should be sought from a medical adviser of Medicare Australia.

### T.8.106. RHINOPLASTY - (ITEMS 45638, 45639)

Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

Item 45638 applies where surgery is indicated for correction of nasal obstruction, post-traumatic deformity (but not as a result of previous elective cosmetic surgery), or both.

Item 45639 applies where surgery is indicated for the correction of significant developmental deformity. Developmental deformity includes cleft nose, bifid tip and twisted nose. Claims for benefits under this item should be accompanied by full clinical details and pre-operative photographs, including front, base (ie inferior view) and two laterals of the nose. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'.

Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

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

### T.8.107. 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.

### T.8.108. VERMILIONECTOMY - (ITEM 45669)

Item 45669 covers treatment of the entire lip.

### T.8.109. 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.

### T.8.110. GENIOPLASTY - (ITEM 45761)

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

### T.8.111. 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.

### T.8.112. 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.

### T.8.113. 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.

### T.8.114. REMOVAL OF MULTIPLE EXOSTOSES (ITEMS 47933 AND 47936)

Items 47933 and 47936 provide for removal of multiple exostoses when undertaken via the same incision.

### T.8.115. LUMBAR DISCECTOMY - (ITEM 48636)

Following an MSAC assessment of Intradiscal Electrothermal Annuloplasty (IDETA), it was recommended that public funding not be supported for IDETA at this time therefore medical benefits are not payable for the IDETA procedure. A restriction has been placed on the item 48636 (lumbar discectomy). This item cannot be claimed for IDETA.

### T.8.116. DISCECTOMY IN RELATION TO ANTERIOR INTERBODY SPINAL FUSION - (ITEMS 48660 TO 48675)

Benefits are not payable for discectomy items claimed in association with anterior interbody fusion items unless discectomy is required to remove expulsed fragments of disc or is undertaken at a level different from where the fusion is performed.

### T.8.117. INTERNAL FIXATION - (ITEMS 48678 TO 48690)

Benefits under these items are only attracted where internal fixation is carried out in association with spinal fusion covered by Items 48642 to 48675. The multiple rule would apply in each instance.

### T.8.118. WRIST SURGERY - (ITEMS 49200 TO 49227)

For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

### T.8.119. 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.

### T.8.120. 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").

### T.8.121. 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.

### T.8.122. NON-RESECTABLE HEPATOCELLULAR CARCINOMA DESTRUCTION OF BY OPEN OR LAPAROSCOPIC RADIOFREQUENCY 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.

### T.8.123. 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.

### T.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.

### T.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.

### T.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.

### T.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 delivery involving Caesarean section.

Where assistance is provided at a Caesarean section delivery and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item 51306.

### T.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.

## T.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 Medicare Australia 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 Medicare benefit for anaesthesia in connection with a procedure is comprised of up to three components:

The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997). For example:

| | |
|---|---|
| 20702 | INITIATION AND MANAGEMENT OF ANAESTHESIA for percutaneous liver biospy (4 basic units)<br>Fee: $77.80 Benefit: 75% $58.35 85% $66.15 |

the time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136), for example;

| | |
|---|---|
| 23033 | - 41 MINUTES to 45 MINUTES (3 units)<br>Fee: $58.35 Benefit: 75%= $43.80 85% = $ 49.60 |

plus, where appropriate

modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020), for example

| | |
|---|---|
| 25015 | ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA where the patients age is less than 12 months of age or 70 years or greater (1 unit)<br>Fee: $19.45 Benefit: 75% $14.60 85% $16.55 |

Each assistant at anaesthesia service in subgroup 26 has also 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 establish the fee for the assistant service. For example:

| | |
|---|---|
| 25200 | 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<br>Derived Fee: An amount of $97.25 (5 basic units)<br>plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020 |

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, using heart-lung machine or equivalent (20 basic units)<br>Fee: $389.00 Benefit: 75% = $291.75 85% = $330.65 |

(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)<br>Fee: $58.35 Benefit: 75%= $43.80 85% = $ 49.60 |

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 units)<br>Fee: $19.45 Benefit: 75% $14.60 85% $16.55 |

### T.10.2. ELIGIBLE SERVICES

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. Under the Health Insurance Regulations, 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.

### T.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, the first 2 hours of time after the first 15 minutes is represented in the Medicare Benefits Schedule by item numbers in 5 minute increments. For example:

| | | | |
|---|---|---|---|
| | ANAESTHESIA, ASSISTANCE AT ANAESTHESIA OR PERFUSION TIME<br>- for anaesthesia in connection with an eligible medical service or a dental service or assistance at anaesthesia in connection with an eligible medical service or for perfusion in connection with an eligible medical service | | |
| 23010 | 15 MINUTES OR LESS (1 unit)<br>Fee: $19.45 | Benefit: 75%= $14.60 | Benefit: 85% = $16.55 |
| 23021 | 16 MINUTES TO 20 MINUTES (2 units)<br>Fee: $38.90 | Benefit: 75%= $29.20 | Benefit: 85% = $33.10 |
| 23022 | 21MINUTES to 25 MINUTES (2 units)<br>Fee: $38.90 | Benefit: 75%= $29.20 | Benefit: 85% = $33.10 |
| 23023 | - 26 MINUTES to 30 MINUTES (2 units)<br>Fee: $38.90 | Benefit: 75%= $29.20 | Benefit: 85% = $33.10 |
| 23031 | - 31 MINUTES to 35 MINUTES (3 units)<br>Fee: $58.35 | Benefit: 75%= $43.80 | Benefit: 85% = $49.60 |
| 23032 | - 36 MINUTES to 40 MINUTES (3 units)<br>Fee: $58.35 | Benefit: 75%= $43.80 | Benefit: 85% = $49.60 |
| 23033 | - 41 MINUTES to 45 MINUTES (3 units)<br>Fee: $58.35 | Benefit: 75%= $43.80 | Benefit: 85% = $49.60 |

For services lasting between 15 minutes and two hours, 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.

## T.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** | **Units** | **SCHEDULE FEE (Units x $ 19.45)** |
| 20840 | Anaesthesia for resection of perforated bowel | 6 | $116.70 |
| 23200 | Time – 4 hours 40 minutes | 24 | $466.80 |
| 25000 | Modifier - Physical status | 1 | $19.45 |
| 22012 | Central Venous Pressure Monitoring | 3 | $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 | Central Venous Pressure Monitoring | 3 | $58.35 |
| | | | |
| | TOTAL UNITS | 34 | Schedule fee = **$661.30** |
| | | | |
| 25025 | Anaesthesia After Hours Emergency Modifier | | Schedule Fee $661.30<br>x 50%<br>**=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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.10.10. PERFUSION SERVICES - (ITEMS 22055 TO 22075)

Perfusion services covered by items 22055-22075 have been included in the RVG format.

***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, 22070 and 22075 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 service must be performed by a medical practitioner in order to attract Medicare benefits. The "on behalf of" provisions do not apply.

### T.10.11. ANAESTHESIA AS A THERAPEUTIC PROCEDURE - (ITEM 21965)

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

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

Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

### T.10.12. DISCONTINUED PROCEDURE - (ITEM 21990)

Claims for benefits under Item 21990 should be submitted to Medicare for approval of benefits and should include full details of the circumstances, including details of the surgery/procedure which had been proposed and the reason for it being discontinued.

### T.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.

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

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

Applications for approval should be addressed to:

**The MCRP Officer**
**PO Box 9822**
**SYDNEY NSW 2001**

### T.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.

### T.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.

### T.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.

### T.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.

### T.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 osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.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.

### T.10.29. ANAESTHESIA FOR ENDOSCOPIC URETERIC SURGERY - INCLUDING LASER PROCEDURE - (ITEM 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

### T.11.1. BOTULINUM TOXIN - (ITEMS 18350 TO 18373)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently two botulinum toxin agents with TGA registration (Botox and Dysport). 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 registered by Medicare Australia to participate in the arrangements under Section 100 of the *National Health Act 1953* relating to the use and supply of Botulinum Toxin.

Items 18354, 18356 and 18358 for the treatment of equinus, equinovarus or equinovalgus are limited to a maximum of 4 injections per patient on any one 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.

Items 18354 to 18358 have been extended to patients 18 years of age and older who have commenced on the PBS subsidised treatment as a paediatric patient. This is in line with the extension of the PBS listing for the supply of the drug for this indication under Section 100(1)(b) of the *National Health Act 1953*.

Botulinum Toxin, which is not supplied and administered in accordance with the arrangements under Section 100 of the *National Health Act 1953*, is not 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.

The Department of Human Services (DHS) has developed a Health Practitioner Guideline to substantiate that a patient had a pre-existing condition at the time of the service which is located on the DHS website.

**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.

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

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

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

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

## GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

### *SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY*

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|---|---|---|---|
| 13015 | 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.<br>*(See para T1.1 of explanatory notes to this Category)*<br>**Fee:** $254.75 | **Benefit:** 75% = $191.10 | 85% = $216.55 |
| 13020 | 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<br>*(See para T1.1 of explanatory notes to this Category)*<br>**Fee:** $258.85 | **Benefit:** 75% = $194.15 | 85% = $220.05 |
| 13025 | 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)<br>*(See para T1.1 of explanatory notes to this Category)*<br>**Fee:** $115.70 | **Benefit:** 75% = $86.80 | 85% = $98.35 |
| 13030 | 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)<br>*(See para T1.1 of explanatory notes to this Category)*<br>**Fee:** $163.45 | **Benefit:** 75% = $122.60 | 85% = $138.95 |

### *SUBGROUP 2 - DIALYSIS*

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| 13100 | 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<br>*(See para T1.2 of explanatory notes to this Category)*<br>**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 time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day<br>*(See para T1.2 of explanatory notes to this Category)*<br>**Fee:** $71.20 | **Benefit:** 75% = $53.40 | 85% = $60.55 |
| 13104 | 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<br>*(See para T1.3 of explanatory notes to this Category)*<br>**Fee:** $147.95 | **Benefit:** 85% = $125.80 | |
| 13106 | DECLOTTING OF AN ARTERIOVENOUS SHUNT<br>**Fee:** $121.35 | **Benefit:** 75% = $91.05 | 85% = $103.15 |
| 13109 | INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)<br>**Fee:** $227.75 | **Benefit:** 75% = $170.85 | 85% = $193.60 |
| 13110 | TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.)<br>**Fee:** $228.50 | **Benefit:** 75% = $171.40 | 85% = $194.25 |
| 13112 | PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.)<br>**Fee:** $136.65 | **Benefit:** 75% = $102.50 | 85% = $116.20 |

| | *SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES* |
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| 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 calendar year<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $3,110.75 **Benefit:** 75% = $2,333.10 85% = $3,036.25<br>**Extended Medicare Safety Net Cap:** $1,675.50 |
| 13201 | 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<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $2,909.75 **Benefit:** 75% = $2,182.35 85% = $2,835.25<br>**Extended Medicare Safety Net Cap:** $2,432.15 |
| 13202 | 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<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $465.55 **Benefit:** 75% = $349.20 85% = $395.75<br>**Extended Medicare Safety Net Cap:** $64.95 |
| 13203 | 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<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $486.75 **Benefit:** 75% = $365.10 85% = $413.75<br>**Extended Medicare Safety Net Cap:** $108.15 |
| 13206 | 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<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $465.55 **Benefit:** 75% = $349.20 85% = $395.75<br>**Extended Medicare Safety Net Cap:** $64.95 |
| 13209 | 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<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $84.70 **Benefit:** 75% = $63.55 85% = $72.00<br>**Extended Medicare Safety Net Cap:** $10.90 |
| 13210 | Professional attendance on a patient by a specialist practising in his or her specialty if:<br>(a) the attendance is by video conference; and<br>(b) item 13209 applies to the attendance; and<br>(c) the patient is not an admitted patient; and<br>(d) the patient:<br>(i) is located both:<br>(A) within a telehealth eligible area; and<br>(B) at the time of the attendance—at least 15 kms by road from the specialist; or<br>(ii) is a care recipient in a residential care service; or<br>(iii) is a patient of:<br>(A) an Aboriginal Medical Service; or<br>(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies<br><br>*(See para T1.22 of explanatory notes to this Category)*<br>**Derived Fee:** 50% of the fee for item 13209. Benefit: 85% of the derived fee<br>**Extended Medicare Safety Net Cap:** $5.30 |

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| 13212 | OOCYTE RETRIEVAL for the purposes of assisted reproductive technologies – only if rendered in conjunction with a service to which Item 13200, 13201 or 13206 applies (Anaes.)<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $354.45 **Benefit:** 75% = $265.85 85% = $301.30<br>**Extended Medicare Safety Net Cap:** $70.35 |
| 13215 | TRANSFER OF EMBRYOS or both ova and sperm to the female reproductive system, excluding artificial insemination – only if rendered in conjunction with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in 1 treatment cycle (Anaes.)<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $111.10 **Benefit:** 75% = $83.35 85% = $94.45<br>**Extended Medicare Safety Net Cap:** $48.70 |
| 13218 | PREPARATION of frozen or donated embryos or donated oocytes for transfer to the female reproductive system, 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.)<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $793.55 **Benefit:** 75% = $595.20 85% = $719.05<br>**Extended Medicare Safety Net Cap:** $702.65 |
| 13221 | PREPARATION OF SEMEN for the purposes of artificial insemination - only if rendered in conjunction with a service to which item 13203 applies<br>*(See para T1.4 of explanatory notes to this Category)*<br>**Fee:** $50.80 **Benefit:** 75% = $38.10 85% = $43.20<br>**Extended Medicare Safety Net Cap:** $21.70 |
| 13251 | INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies<br>*(See para T1.5 of explanatory notes to this Category)*<br>**Fee:** $417.95 **Benefit:** 75% = $313.50 85% = $355.30<br>**Extended Medicare Safety Net Cap:** $108.15 |
| 13290 | 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<br>**Fee:** $204.25 **Benefit:** 75% = $153.20 85% = $173.65 |
| 13292 | 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.)<br>**Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40 |
| | *SUBGROUP 4 - PAEDIATRIC & NEONATAL* |
| 13300 | UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate<br>**Fee:** $56.95 **Benefit:** 75% = $42.75 85% = $48.45 |
| 13303 | UMBILICAL ARTERY CATHETERISATION with or without infusion<br>**Fee:** $84.40 **Benefit:** 75% = $63.30 85% = $71.75 |
| 13306 | BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor<br>**Fee:** $334.10 **Benefit:** 75% = $250.60 85% = $284.00 |
| 13309 | BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected<br>**Fee:** $284.85 **Benefit:** 75% = $213.65 85% = $242.15 |
| 13312 | BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS<br>**Fee:** $28.45 **Benefit:** 75% = $21.35 85% = $24.20 |
| 13318 | CENTRAL VEIN CATHETERISATION - by open exposure in a person under 12 years of age (Anaes.)<br>*(See para T1.6 of explanatory notes to this Category)*<br>**Fee:** $227.45 **Benefit:** 75% = $170.60 85% = $193.35 |
| 13319 | CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.)<br>**Fee:** $227.45 **Benefit:** 75% = $170.60 85% = $193.35 |

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| | *SUBGROUP 5 - CARDIOVASCULAR* |
| 13400 | RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.)<br>**Fee:** $96.80 **Benefit:** 75% = $72.60 85% = $82.30 |
| | *SUBGROUP 6 - GASTROENTEROLOGY* |
| 13500 | GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE<br>**Fee:** $180.30 **Benefit:** 75% = $135.25 85% = $153.30 |
| 13503 | GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE<br>**Fee:** $360.70 **Benefit:** 75% = $270.55 85% = $306.60 |
| 13506 | GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices<br>**Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85 |
| | *SUBGROUP 8 - HAEMATOLOGY* |
| 13700 | HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.)<br>**Fee:** $333.25 **Benefit:** 75% = $249.95 85% = $283.30 |
| 13703 | ADMINISTRATION OF BLOOD, including collection from donor<br>**Fee:** $119.50 **Benefit:** 75% = $89.65 85% = $101.60 |
| 13706 | ADMINISTRATION OF BLOOD or bone marrow already collected<br>*(See para T1.7 of explanatory notes to this Category)*<br>**Fee:** $83.35 **Benefit:** 75% = $62.55 85% = $70.85 |
| 13709 | COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation<br>*(See para T1.8 of explanatory notes to this Category)*<br>**Fee:** $48.45 **Benefit:** 75% = $36.35 85% = $41.20 |
| 13750 | THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day<br>**Fee:** $136.65 **Benefit:** 75% = $102.50 85% = $116.20 |
| 13755 | DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermitten flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day<br>**Fee:** $136.65 **Benefit:** 75% = $102.50 85% = $116.20 |
| 13757 | THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda<br>**Fee:** $72.95 **Benefit:** 75% = $54.75 85% = $62.05 |
| 13760 | IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for:<br>. chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or<br>. Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or<br>. acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or<br>. multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or<br>. small round cell sarcomas; or<br>. primitive neuroectodermal tumour; or<br>. germ cell tumours which have relapsed following, or are refractory to, chemotherapy;<br>. germ cell tumours which have had an incomplete response to first line therapy.<br>- performed under the supervision of a consultant physician - each day.<br>**Fee:** $762.60 **Benefit:** 75% = $571.95 85% = $688.10 |

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| | *SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT* |
| 13815 | CENTRAL VEIN CATHETERISATION by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.)<br>*(See para T1.6 of explanatory notes to this Category)*<br>**Fee:** $85.25 **Benefit:** 75% = $63.95 85% = $72.50 |
| 13818 | RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.)<br>*(See para T1.10 of explanatory notes to this Category)*<br>**Fee:** $113.70 **Benefit:** 75% = $85.30 85% = $96.65 |
| 13830 | INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day<br>**Fee:** $75.35 **Benefit:** 75% = $56.55 85% = $64.05 |
| 13839 | ARTERIAL PUNCTURE and collection of blood for diagnostic purposes<br>**Fee:** $23.05 **Benefit:** 75% = $17.30 85% = $19.60 |
| 13842 | INTRAARTERIAL CANNULATION for the purpose of taking multiple arterial blood samples for blood gas analysis<br>*(See para T1.10 of explanatory notes to this Category)*<br>**Fee:** $69.30 **Benefit:** 75% = $52.00 85% = $58.95 |
| 13847 | COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day including initial and subsequent consultations and monitoring of parameters (Anaes.)<br>*(See para T1.10 of explanatory notes to this Category)*<br>**Fee:** $156.10 **Benefit:** 75% = $117.10 85% = $132.70 |
| 13848 | COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters<br>*(See para T1.10 of explanatory notes to this Category)*<br>**Fee:** $131.05 **Benefit:** 75% = $98.30 85% = $111.40 |
| 13851 | CIRCULATORY SUPPORT DEVICE, management of, on first day<br>**Fee:** $493.65 **Benefit:** 75% = $370.25 85% = $419.65 |
| 13854 | CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first<br>**Fee:** $114.85 **Benefit:** 75% = $86.15 85% = $97.65 |
| 13857 | AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (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<br>*(See para T1.10 of explanatory notes to this Category)*<br>**Fee:** $146.40 **Benefit:** 75% = $109.80 85% = $124.45 |
| | *SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT* |
| 13870 | ***(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit)***<br>MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on the first day<br>*(See para T1.9 and T1.11 of explanatory notes to this Category)*<br>**Fee:** $362.10 **Benefit:** 75% = $271.60 |
| 13873 | MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day<br>*(See para T1.9 and T1.11 of explanatory notes to this Category)*<br>**Fee:** $268.60 **Benefit:** 75% = $201.45 |

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| 13876 | CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - once only for each type of pressure on any calendar day (up to a maximum of 4 pressures)<br>*(See para T1.9 and T1.11 of explanatory notes to this Category)*<br>**Fee:** $76.90 **Benefit:** 75% = $57.70 |
| 13881 | AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support<br>*(See para T1.9 and T1.11 of explanatory notes to this Category)*<br>**Fee:** $146.40 **Benefit:** 75% = $109.80 |
| 13882 | VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day<br>*(See para T1.9 and T1.11 of explanatory notes to this Category)*<br>**Fee:** $115.25 **Benefit:** 75% = $86.45 |
| 13885 | CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day<br>*(See para T1.9 and T1.11 of explanatory notes to this Category)*<br>**Fee:** $153.65 **Benefit:** 75% = $115.25 |
| 13888 | CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day<br>*(See para T1.9 and T1.11 of explanatory notes to this Category)*<br>**Fee:** $76.90 **Benefit:** 75% = $57.70 |
| | *SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES* |
| 13915 | CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin or for the administration of drugs used immediately prior to, or with microwave (UHF radiowave) cancer therapy alone<br>*(See para T1.12 of explanatory notes to this Category)*<br>**Fee:** $65.05 **Benefit:** 75% = $48.80 85% = $55.30 |
| 13918 | CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day<br>**Fee:** $97.95 **Benefit:** 75% = $73.50 85% = $83.30 |
| 13921 | CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment<br>**Fee:** $110.80 **Benefit:** 75% = $83.10 85% = $94.20 |
| 13924 | 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<br>**Fee:** $65.25 **Benefit:** 75% = $48.95 85% = $55.50 |
| 13927 | 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 more than 1 hours duration - payable once only on the same day<br>**Fee:** $84.40 **Benefit:** 75% = $63.30 85% = $71.75 |
| 13930 | 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<br>**Fee:** $117.80 **Benefit:** 75% = $88.35 85% = $100.15 |
| 13933 | CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment<br>**Fee:** $130.70 **Benefit:** 75% = $98.05 85% = $111.10 |
| 13936 | CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode<br>**Fee:** $85.15 **Benefit:** 75% = $63.90 85% = $72.40 |

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| 13939 | IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies<br>*(See para T1.13 of explanatory notes to this Category)*<br>**Fee:** $97.95 **Benefit:** 75% = $73.50 85% = $83.30 |
| 13942 | 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<br>*(See para T1.13 of explanatory notes to this Category)*<br>**Fee:** $65.25 **Benefit:** 75% = $48.95 85% = $55.50 |
| 13945 | LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of<br>**Fee:** $52.50 **Benefit:** 75% = $39.40 85% = $44.65 |
| 13948 | CYTOTOXIC AGENT, instillation of, into a body cavity<br>**Fee:** $65.25 **Benefit:** 75% = $48.95 85% = $55.50 |
| | *SUBGROUP 12 - DERMATOLOGY* |
| 14050 | PUVA THERAPY or UVB THERAPY administered in whole body cabinet, not being a service associated with a service to which item 14053 applies including associated consultations other than an initial consultation<br>*(See para T1.14 of explanatory notes to this Category)*<br>**Fee:** $52.75 **Benefit:** 75% = $39.60 85% = $44.85 |
| 14053 | PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation<br>*(See para T1.14 of explanatory notes to this Category)*<br>**Fee:** $52.75 **Benefit:** 75% = $39.60 85% = $44.85 |
| 14100 | LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of vascular lesions of the head or neck where abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period (Anaes.)<br>**Fee:** $152.50 **Benefit:** 75% = $114.40 85% = $129.65<br>**Extended Medicare Safety Net Cap:** $122.00 |
| 14106 | LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), where the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm$^2$ (Anaes.)<br>*(See para T1.15 of explanatory notes to this Category)*<br>**Fee:** $152.50 **Benefit:** 75% = $114.40 85% = $129.65 |
| 14109 | LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm$^2$ and up to 100cm$^2$ (Anaes.)<br>*(See para T1.15 of explanatory notes to this Category)*<br>**Fee:** $187.35 **Benefit:** 75% = $140.55 85% = $159.25 |
| 14112 | LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm$^2$ and up to 150cm$^2$ (Anaes.)<br>*(See para T1.15 of explanatory notes to this Category)*<br>**Fee:** $221.75 **Benefit:** 75% = $166.35 85% = $188.50 |
| 14115 | LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm$^2$ and up to 250cm$^2$ (Anaes.)<br>*(See para T1.15 of explanatory notes to this Category)*<br>**Fee:** $256.50 **Benefit:** 75% = $192.40 85% = $218.05 |

| MISCELLANEOUS | | | | OTHER |
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| 14118 | LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-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 items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 250cm$^2$ (Anaes.)<br>*(See para T1.15 of explanatory notes to this Category)*<br>**Fee:** $325.75 | **Benefit:** 75% = $244.35 | 85% = $276.90 | |
| 14124 | LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of haemangiomas of infancy, including any associated consultation - ***where a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes.)<br>*(See para T1.15 and T1.16 of explanatory notes to this Category)*<br>**Fee:** $152.50 | **Benefit:** 75% = $114.40 | 85% = $129.65 | |
| | *SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES* | | | |
| 14200 | GASTRIC LAVAGE in the treatment of ingested poison<br>**Fee:** $59.80 | **Benefit:** 75% = $44.85 | 85% = $50.85 | |
| 14201 | 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<br>*(See para T1.17 of explanatory notes to this Category)*<br>**Fee:** $236.85<br>**Extended Medicare Safety Net Cap:** $35.55 | **Benefit:** 75% = $177.65 | 85% = $201.35 | |
| 14202 | 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<br>*(See para T1.17 of explanatory notes to this Category)*<br>**Fee:** $119.90<br>**Extended Medicare Safety Net Cap:** $18.00 | **Benefit:** 75% = $89.95 | 85% = $101.95 | |
| 14203 | HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)<br>*(See para T1.18 of explanatory notes to this Category)*<br>**Fee:** $51.15 | **Benefit:** 75% = $38.40 | 85% = $43.50 | |
| 14206 | HORMONE OR LIVING TISSUE IMPLANTATION by cannula<br>*(See para T1.18 of explanatory notes to this Category)*<br>**Fee:** $35.60 | **Benefit:** 75% = $26.70 | 85% = $30.30 | |
| 14209 | INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent<br>**Fee:** $88.70 | **Benefit:** 75% = $66.55 | 85% = $75.40 | |
| 14212 | INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)<br>**Fee:** $185.30 | **Benefit:** 75% = $139.00 | 85% = $157.55 | |
| 14215 | LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid<br>**Fee:** $97.95 | **Benefit:** 75% = $73.50 | 85% = $83.30 | |
| 14218 | 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<br>**Fee:** $97.95 | **Benefit:** 75% = $73.50 | 85% = $83.30 | |
| 14221 | LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies<br>**Fee:** $52.50 | **Benefit:** 75% = $39.40 | 85% = $44.65 | |
| 14224 | ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)<br>**Fee:** $70.35 | **Benefit:** 75% = $52.80 | 85% = $59.80 | |
| 14227 | 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<br>*(See para T1.19 of explanatory notes to this Category)*<br>**Fee:** $97.95 | **Benefit:** 75% = $73.50 | 85% = $83.30 | |

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| 14230 | 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.)<br>*(See para T1.19 of explanatory notes to this Category)*<br>**Fee:** $298.05 **Benefit:** 75% = $223.55 | |
| 14233 | 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.)<br>*(See para T1.19 of explanatory notes to this Category)*<br>**Fee:** $361.90 **Benefit:** 75% = $271.45 | |
| 14236 | INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER 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.)<br>*(See para T1.19 of explanatory notes to this Category)*<br>**Fee:** $659.95 **Benefit:** 75% = $495.00 | |
| 14239 | Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.)<br>*(See para T1.19 of explanatory notes to this Category)*<br>**Fee:** $159.40 **Benefit:** 75% = $119.55 | |
| 14242 | SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.)<br>*(See para T1.19 of explanatory notes to this Category)*<br>**Fee:** $473.65 **Benefit:** 75% = $355.25 | |
| 14245 | 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<br>*(See para T1.20 of explanatory notes to this Category)*<br>**Fee:** $97.95 **Benefit:** 75% = $73.50 85% = $83.30 | |

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| | **GROUP T2 - RADIATION ONCOLOGY** |
| | *SUBGROUP 1 - SUPERFICIAL* |
| 15000 | *(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)*<br><br>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 fractionated treatment is given<br>- 1 field<br>**Fee:** $42.55 **Benefit:** 75% = $31.95 85% = $36.20 |
| 15003 | - 2 or more fields up to a maximum of 5 additional fields<br>**Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $17.10 |
| 15006 | RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied<br>- 1 field<br>**Fee:** $94.35 **Benefit:** 75% = $70.80 85% = $80.20 |
| 15009 | - 2 or more fields up to a maximum of 5 additional fields<br>**Derived Fee:** The fee for item 15006 plus for each field in excess of 1, an amount of $18.55 |
| 15012 | RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye<br>**Fee:** $53.45 **Benefit:** 75% = $40.10 85% = $45.45 |
| | *SUBGROUP 2 - ORTHOVOLTAGE* |
| 15100 | RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week<br>- 1 field<br>**Fee:** $47.70 **Benefit:** 75% = $35.80 85% = $40.55 |
| 15103 | - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)<br>**Derived Fee:** The fee for item 15100 plus for each field in excess of 1, an amount of $18.80 |
| 15106 | RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently<br>- 1 field<br>**Fee:** $56.30 **Benefit:** 75% = $42.25 85% = $47.90 |
| 15109 | - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)<br>**Derived Fee:** The fee for item 15106 plus for each field in excess of 1, an amount of $22.70 |
| 15112 | RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field<br>**Fee:** $120.25 **Benefit:** 75% = $90.20 85% = $102.25 |
| 15115 | - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)<br>**Derived Fee:** The fee for item 15112 plus for each field in excess of 1, an amount of $47.30 |
| | *SUBGROUP 3 - MEGAVOLTAGE* |
| 15211 | RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given<br>- 1 field<br>**Fee:** $54.70 **Benefit:** 75% = $41.05 85% = $46.50 |
| 15214 | - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)<br>**Derived Fee:** The fee for item 15211 plus for each field in excess of 1, an amount of $31.90 |
| 15215 | 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)<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 |
| 15218 | 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 (prostate)<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 |

| RADIATION ONCOLOGY | | MEGAVOLTAGE |
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| 15221 | 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 (breast)<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15224 | 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<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15227 | 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<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15230 | 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)<br>**Derived Fee:** The fee for item 15215 plus for each field in excess of 1, an amount of $37.95 | |
| 15233 | 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)<br>**Derived Fee:** The fee for item 15218 plus for each field in excess of 1, an amount of $37.95 | |
| 15236 | 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)<br>**Derived Fee:** The fee for item 15221 plus for each field in excess of 1, an amount of $37.95 | |
| 15239 | 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 for diseases and conditions not covered by items 15230, 15233 or 15236<br>**Derived Fee:** The fee for item 15224 plus for each field in excess of 1, an amount of $37.95 | |
| 15242 | 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<br>**Derived Fee:** The fee for item 15227 plus for each field in excess of 1, an amount of $37.95 | |
| 15245 | 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 (lung)<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15248 | 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 (prostate)<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15251 | 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)<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15254 | 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<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15257 | 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 secondary site<br>**Fee:** $59.65 **Benefit:** 75% = $44.75 85% = $50.75 | |
| 15260 | 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 3 fields) - treatment delivered to primary site (lung)<br>**Derived Fee:** The fee for item 15245 plus for each field in excess of 1, an amount of $37.95 | |

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| 15263 | 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 3 fields) - treatment delivered to primary site (prostate)<br>**Derived Fee:** The fee for item 15248 plus for each field in excess of 1, an amount of $37.95 |
| 15266 | 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 3 fields) - treatment delivered to primary site (breast)<br>**Derived Fee:** The fee for item 15251 plus for each field in excess of 1, an amount of $37.95 |
| 15269 | 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 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266<br>**Derived Fee:** The fee for item 15254 plus for each field in excess of 1, an amount of $37.95 |
| 15272 | 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 3 fields) - treatment delivered to secondary site<br>**Derived Fee:** The fee for item 15257 plus for each field in excess of 1, an amount of $37.95 |
| | *SUBGROUP 4 - BRACHYTHERAPY* |
| 15303 | INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)<br>**Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45 |
| 15304 | INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)<br>**Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45 |
| 15307 | 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 (Anaes.)<br>**Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $602.30 |
| 15308 | INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)<br>**Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $602.30 |
| 15311 | INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)<br>**Fee:** $333.20 **Benefit:** 75% = $249.90 85% = $283.25 |
| 15312 | INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)<br>**Fee:** $330.80 **Benefit:** 75% = $248.10 85% = $281.20 |
| 15315 | INTRAVAGINAL 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 (Anaes.)<br>**Fee:** $654.25 **Benefit:** 75% = $490.70 85% = $579.75 |
| 15316 | INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)<br>**Fee:** $654.25 **Benefit:** 75% = $490.70 85% = $579.75 |
| 15319 | COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15 |
| 15320 | COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15 |
| 15323 | COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)<br>**Fee:** $722.00 **Benefit:** 75% = $541.50 85% = $647.50 |

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| 15324 | COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)<br>**Fee:** $722.00 **Benefit:** 75% = $541.50 85% = $647.50 |
| 15327 | IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.)<br>**Fee:** $785.45 **Benefit:** 75% = $589.10 85% = $710.95 |
| 15328 | IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.)<br>**Fee:** $785.45 **Benefit:** 75% = $589.10 85% = $710.95 |
| 15331 | IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.)<br>**Fee:** $745.80 **Benefit:** 75% = $559.35 85% = $671.30 |
| 15332 | IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.)<br>**Fee:** $745.80 **Benefit:** 75% = $559.35 85% = $671.30 |
| 15335 | IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.)<br>**Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $602.30 |
| 15336 | IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.)<br>**Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $602.30 |
| 15338 | PROSTATE, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist. *(See para T2.2 of explanatory notes to this Category)*<br>**Fee:** $935.60 **Benefit:** 75% = $701.70 85% = $861.10 |
| 15339 | REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.)<br>**Fee:** $76.20 **Benefit:** 75% = $57.15 85% = $64.80 |
| 15342 | CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site<br>**Fee:** $190.30 **Benefit:** 75% = $142.75 85% = $161.80 |
| 15345 | CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites<br>**Fee:** $507.80 **Benefit:** 75% = $380.85 85% = $433.30 |
| 15348 | SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance<br>**Fee:** $58.40 **Benefit:** 75% = $43.80 85% = $49.65 |
| 15351 | CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface<br>**Fee:** $116.60 **Benefit:** 75% = $87.45 85% = $99.15 |
| 15354 | CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface<br>**Fee:** $141.50 **Benefit:** 75% = $106.15 85% = $120.30 |
| 15357 | SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance<br>**Fee:** $40.05 **Benefit:** 75% = $30.05 85% = $34.05 |

*SUBGROUP 5 - COMPUTERISED PLANNING*

**RADIOTHERAPY PLANNING**

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| 15500 | RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies)<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $242.65 | **Benefit:** 75% = $182.00 | 85% = $206.30 |
| 15503 | RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies)<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $311.55 | **Benefit:** 75% = $233.70 | 85% = $264.85 |
| 15506 | RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies)<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $465.30 | **Benefit:** 75% = $349.00 | 85% = $395.55 |
| 15509 | RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies)<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $210.30 | **Benefit:** 75% = $157.75 | 85% = $178.80 |
| 15512 | RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies)<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $271.10 | **Benefit:** 75% = $203.35 | 85% = $230.45 |
| 15513 | RADIATION SOURCE LOCALISATION using a simulator or x-ray machine or CT of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338<br>**Fee:** $306.55 | **Benefit:** 75% = $229.95 | 85% = $260.60 |
| 15515 | RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies)<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $392.50 | **Benefit:** 75% = $294.40 | 85% = $333.65 |
| 15518 | RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $77.00 | **Benefit:** 75% = $57.75 | 85% = $65.45 |
| 15521 | RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $339.90 | **Benefit:** 75% = $254.95 | 85% = $288.95 |
| 15524 | RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $637.35 | **Benefit:** 75% = $478.05 | 85% = $562.85 |
| 15527 | RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $78.95 | **Benefit:** 75% = $59.25 | 85% = $67.15 |
| 15530 | RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $352.15 | **Benefit:** 75% = $264.15 | 85% = $299.35 |

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| 15533 | RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $667.70 **Benefit:** 75% = $500.80 85% = $593.20 |
| 15536 | BRACHYTHERAPY PLANNING, computerised radiation dosimetry<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $266.90 **Benefit:** 75% = $200.20 85% = $226.90 |
| 15539 | BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338<br>**Fee:** $627.30 **Benefit:** 75% = $470.50 85% = $552.80 |
| 15550 | SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenous contrast medium, where:<br>(a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and<br>(b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and<br>(c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and<br>(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $658.60 **Benefit:** 75% = $493.95 85% = $584.10 |
| 15553 | SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where:<br>(a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and<br>(b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and<br>(c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and<br>(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $710.55 **Benefit:** 75% = $532.95 85% = $636.05 |
| 15556 | DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where:<br>(a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and<br>(b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and<br>(c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and<br>(d) dose volume histograms must be generated, approved and recorded with the plan; and<br>(e) a CT image volume dataset must be used for the relevant region to be planned and treated; and<br>(f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $664.40 **Benefit:** 75% = $498.30 85% = $589.90 |
| 15559 | DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where:<br>(a) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, two planning target volumes and one organ at risk defined in the prescription; or<br>(b) 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 two organ at risk dose goals or constraints defined in the prescription; or<br>(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.<br><br>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<br>*(See para T2.3 of explanatory notes to this Category)*<br>**Fee:** $866.55 **Benefit:** 75% = $649.95 85% = $792.05 |

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| | DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where:<br>(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<br>(b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and<br>(i) two planning target volumes; or<br>(ii) two organ at risk dose goals or constraints defined in the prescription.<br>or<br>(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;<br>or<br>(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.<br><br>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<br>*(See para T2.3 of explanatory notes to this Category)* |
| 15562 | **Fee:** $1,120.75 **Benefit:** 75% = $840.60 85% = $1,046.25 |
| | *SUBGROUP 6 - STEREOTACTIC RADIOSURGERY* |
| | STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment |
| 15600 | **Fee:** $1,702.30 **Benefit:** 75% = $1,276.75 85% = $1,627.80 |
| | *SUBGROUP 7 - RADIATION ONCOLOGY TREATMENT VERIFICATION* |
| | RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double 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).<br>*(See para T2.4 of explanatory notes to this Category)* |
| 15700 | **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).<br>*(See para T2.4 of explanatory notes to this Category)* |
| 15705 | **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).<br>(see para T2.5 of explanatory notes to this Category) |
| 15710 | **Fee:** $76.60 **Benefit:** 75% = $57.45 85% = $65.15 |
| | *SUBGROUP 8 - BRACHYTHERAPY PLANNING AND VERIFICATION* |
| | BRACHYTHERAPY TREATMENT VERIFICATION – maximum of one only for each attendance.<br>*(See para T2.4 of explanatory notes to this Category)* |
| 15800 | **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 |

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| | **GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE** |
| 16003 | 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.)<br>*(See para T3.1 of explanatory notes to this Category)*<br>**Fee:** $650.50 **Benefit:** 75% = $487.90 85% = $576.00 |
| 16006 | ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique<br>**Fee:** $499.85 **Benefit:** 75% = $374.90 85% = $425.35 |
| 16009 | ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique<br>**Fee:** $341.15 **Benefit:** 75% = $255.90 85% = $290.00 |
| 16012 | INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32<br>**Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90 |
| 16015 | ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either:<br>(i) the disease is poorly controlled by conventional radiotherapy; or<br>(ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain<br>**Fee:** $4,085.70 **Benefit:** 75% = $3,064.30 85% = $4,011.20 |
| 16018 | 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.<br>**Fee:** $2,442.45 **Benefit:** 75% = $1,831.85 85% = $2,367.95 |

## 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

*(See para T4.12 of explanatory notes to this Category)*
**Derived Fee:** 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee
16399 **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
*(See para T4.1 of explanatory notes to this Category)*
**Fee:** $27.25 **Benefit:** 85% = $23.20
16400 **Extended Medicare Safety Net Cap:** $11.05

OBSTETRIC SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL

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 INITIAL attendance, in a single course of treatment - not being a service to which item 104 applies.
**Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75
16401 **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.
**Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55
16404 **Extended Medicare Safety Net Cap:** $32.95

32-36 WEEK OBSTETRIC VISIT
Antenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient's pregnancy when the patient is referred by a participating midwife. Payable only once for a pregnancy.
**Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90
16406 **Extended Medicare Safety Net Cap:** $108.15

ANTENATAL ATTENDANCE
*(See para T4.3 of explanatory notes to this Category)*
**Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10
16500 **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 T4.4 of explanatory notes to this Category)*
**Fee:** $140.55 **Benefit:** 75% = $105.45 85% = $119.50
16501 **Extended Medicare Safety Net Cap:** $65.90

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| 16502 | 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<br>**Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10<br>**Extended Medicare Safety Net Cap:** $22.00 |
| 16504 | TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance<br>**Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10<br>**Extended Medicare Safety Net Cap:** $22.00 |
| 16505 | THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance<br>**Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10<br>**Extended Medicare Safety Net Cap:** $22.00 |
| 16508 | PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day<br>**Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10<br>**Extended Medicare Safety Net Cap:** $22.00 |
| 16509 | PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance<br>**Fee:** $47.15 **Benefit:** 75% = $35.40 85% = $40.10<br>**Extended Medicare Safety Net Cap:** $22.00 |
| 16511 | CERVIX, purse string ligation of (Anaes.)<br>**Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00<br>**Extended Medicare Safety Net Cap:** $109.75 |
| 16512 | CERVIX, removal of purse string ligature of (Anaes.)<br>**Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00<br>**Extended Medicare Safety Net Cap:** $32.95 |
| 16514 | ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)<br>**Fee:** $36.65 **Benefit:** 75% = $27.50 85% = $31.20<br>**Extended Medicare Safety Net Cap:** $16.55 |
| | **MANAGEMENT OF LABOUR AND DELIVERY** |
| 16515 | MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.)<br>*(See para T4.5 of explanatory notes to this Category)*<br>**Fee:** $450.65 **Benefit:** 75% = $338.00 85% = $383.10<br>**Extended Medicare Safety Net Cap:** $175.60 |
| 16518 | MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.)<br>*(See para T4.5 of explanatory notes to this Category)*<br>**Fee:** $450.65 **Benefit:** 75% = $338.00 85% = $383.10<br>**Extended Medicare Safety Net Cap:** $175.60 |
| 16519 | MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)<br>*(See para T4.5 of explanatory notes to this Category)*<br>**Fee:** $693.95 **Benefit:** 75% = $520.50 85% = $619.45<br>**Extended Medicare Safety Net Cap:** $329.15 |
| 16520 | CAESAREAN SECTION and post-operative care for 7 days where 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.)<br>*(See para T4.6 of explanatory notes to this Category)*<br>**Fee:** $811.05 **Benefit:** 75% = $608.30 85% = $736.55<br>**Extended Medicare Safety Net Cap:** $329.15 |

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| 16522 | MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days:<br><br>- multiple pregnancy;<br>- recurrent antepartum haemorrhage from 20 weeks gestation;<br>- grades 2, 3 or 4 placenta praevia;<br>- baby with a birth weight less than or equal to 2500gm;<br>- pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring;<br>- trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery;<br>- pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mm Hg associated with at least 1+ proteinuria on urinalysis;<br>- prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress;<br>- fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR<br>- conditions that pose a significant risk of maternal death. (Anaes.)<br>*(See para T4.7 of explanatory notes to this Category)*<br>**Fee:** $1,629.35 **Benefit:** 75% = $1,222.05 85% = $1,554.85<br>**Extended Medicare Safety Net Cap:** $438.90 |
| 16525 | MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.)<br>*(See para T4.5 of explanatory notes to this Category)*<br>**Fee:** $384.35 **Benefit:** 75% = $288.30 85% = $326.70<br>**Extended Medicare Safety Net Cap:** $153.70 |
| 16527 | MANAGEMENT OF VAGINAL DELIVERY, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery. Payable once only for a pregnancy. (Anaes.)<br>*(See para T4.8 of explanatory notes to this Category)*<br>**Fee:** $450.65 **Benefit:** 75% = $338.00 85% = $383.10<br>**Extended Medicare Safety Net Cap:** $175.60 |
| 16528 | 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.)<br>*(See para T4.8 of explanatory notes to this Category)*<br>**Fee:** $811.05 **Benefit:** 75% = $608.30 85% = $736.55<br>**Extended Medicare Safety Net Cap:** $329.15 |
| | **POST-PARTUM CARE** |
| 16564 | 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.)<br>*(See para T4.10 of explanatory notes to this Category)*<br>**Fee:** $218.00 **Benefit:** 75% = $163.50 85% = $185.30<br>**Extended Medicare Safety Net Cap:** $219.45 |
| 16567 | MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.)<br>*(See para T4.10 of explanatory notes to this Category)*<br>**Fee:** $318.80 **Benefit:** 75% = $239.10 85% = $271.00<br>**Extended Medicare Safety Net Cap:** $219.45 |
| 16570 | ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.)<br>*(See para T4.10 of explanatory notes to this Category)*<br>**Fee:** $416.05 **Benefit:** 75% = $312.05 85% = $353.65<br>**Extended Medicare Safety Net Cap:** $219.45 |
| 16571 | CERVIX, repair of extensive laceration or lacerations (Anaes.)<br>*(See para T4.10 of explanatory notes to this Category)*<br>**Fee:** $318.80 **Benefit:** 75% = $239.10 85% = $271.00<br>**Extended Medicare Safety Net Cap:** $219.45 |
| 16573 | THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)<br>*(See para T4.10 of explanatory notes to this Category)*<br>**Fee:** $259.80 **Benefit:** 75% = $194.85 85% = $220.85<br>**Extended Medicare Safety Net Cap:** $219.45 |

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| 16590 | Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery, payable once only for any pregnancy that has progressed beyond 20 weeks where the practitioner intends to undertake the delivery for a privately admitted patient, not being a service to which item 16591 applies.<br>**Fee:** $324.10 **Benefit:** 75% = $243.10 85% = $275.50<br>**Extended Medicare Safety Net Cap:** $219.45 |
| 16591 | Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies.<br>**Fee:** $142.65 **Benefit:** 75% = $107.00 85% = $121.30<br>**Extended Medicare Safety Net Cap:** $109.75 |
| | **INTERVENTIONAL TECHNIQUES** |
| 16600 | AMNIOCENTESIS, diagnostic<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00<br>**Extended Medicare Safety Net Cap:** $32.95 |
| 16603 | CHORIONIC VILLUS SAMPLING, by any route<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $121.85 **Benefit:** 75% = $91.40 85% = $103.60<br>**Extended Medicare Safety Net Cap:** $65.90 |
| 16606 | FETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or foetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $243.25 **Benefit:** 75% = $182.45 85% = $206.80<br>**Extended Medicare Safety Net Cap:** $131.75 |
| 16609 | FETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.)<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $496.00 **Benefit:** 75% = $372.00 85% = $421.60<br>**Extended Medicare Safety Net Cap:** $252.40 |
| 16612 | FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.)<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $390.25 **Benefit:** 75% = $292.70 85% = $331.75 |
| 16615 | FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70 |
| 16618 | AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70<br>**Extended Medicare Safety Net Cap:** $104.30 |
| 16621 | AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70 |
| 16624 | FETAL FLUID FILLED CAVITY, drainage of<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $299.10 **Benefit:** 75% = $224.35 85% = $254.25<br>**Extended Medicare Safety Net Cap:** $142.65 |
| 16627 | FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Fee:** $608.95 **Benefit:** 75% = $456.75 85% = $534.45<br>**Extended Medicare Safety Net Cap:** $307.25 |

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| 16633 | PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested<br>**Extended Medicare Safety Net Cap:** $230.50 |
| 16636 | PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624<br>*(See para T4.11 of explanatory notes to this Category)*<br>**Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested<br>**Extended Medicare Safety Net Cap:** $87.85 |

## GROUP T6 - ANAESTHETICS

### *SUBGROUP 1 - ANAESTHESIA CONSULTATIONS*

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| 17609 | Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if:<br>(a) the attendance is by video conference; and<br>(b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and<br>(c) the patient is not an admitted patient; and<br>(d) the patient:<br>(i) is located both:<br>(A) within a telehealth eligible area; and<br>(B) at the time of the attendance—at least 15 kms by road from the specialist; or<br>(ii) is a care recipient in a residential care service; or<br>(iii) is a patient of:<br>(A) an Aboriginal Medical Service; or<br>(B) an Aboriginal Community Controlled Health Service;<br>for which a direction made under subsection 19 (2) of the Act applies<br><br>**Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500, whichever is the lesser amount**<br><br>*(See para T6.4 of explanatory notes to this Category)*<br>**Derived Fee:** 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee |
| 17610 | **ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION**<br><br>(Professional attendance by a medical practitioner in the practice of ANAESTHESIA)<br><br>- a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system)<br><br>- *AND of not more than 15 minutes s duration,* not being a service associated with a service to which items 2801 - 3000 apply<br><br>*(See para T6.1 of explanatory notes to this Category)*<br>**Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55<br>**Extended Medicare Safety Net Cap:** $129.00 |
| 17615 | - 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<br><br>- *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<br><br>*(See para T6.1 of explanatory notes to this Category)*<br>**Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75<br>**Extended Medicare Safety Net Cap:** $256.65 |
| 17620 | - 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<br><br>- *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<br><br>*(See para T6.1 of explanatory notes to this Category)*<br>**Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75<br>**Extended Medicare Safety Net Cap:** $355.50 |
| 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<br><br>- *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply<br><br>*(See para T6.1 of explanatory notes to this Category)*<br>**Fee:** $150.90 **Benefit:** 75% = $113.20 85% = $128.30<br>**Extended Medicare Safety Net Cap:** $452.70 |

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| | **ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)**<br><br>(Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her)<br><br>- a BRIEF consultation involving a short history and limited examination<br><br>- *AND of not more than 15 minutes duration*, not being a service associated with a service to which items 2801 – 3000 apply<br><br>*(See para T6.2 of explanatory notes to this Category)*<br>**Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55<br>17640 **Extended Medicare Safety Net Cap:** $129.00 |
| | - a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan<br><br>- *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 apply.<br><br>*(See para T6.2 of explanatory notes to this Category)*<br>**Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75<br>17645 **Extended Medicare Safety Net Cap:** $256.65 |
| | - a consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan<br><br>- *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<br><br>*(See para T6.2 of explanatory notes to this Category)*<br>**Fee:** $118.50 **Benefit:** 75% = $88.90 85% = $100.75<br>17650 **Extended Medicare Safety Net Cap:** $355.50 |
| | - 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,<br><br>- *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply.<br>*(See para T6.2 of explanatory notes to this Category)*<br>**Fee:** $150.90 **Benefit:** 75% = $113.20 85% = $128.30<br>17655 **Extended Medicare Safety Net Cap:** $452.70 |
| | **ANAESTHETIST, CONSULTATION, OTHER**<br><br>(Professional attendance by an anaesthetist in the practice of ANAESTHESIA)<br><br>- 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.<br>*(See para T6.3 of explanatory notes to this Category)*<br>**Fee:** $85.55 **Benefit:** 75% = $64.20 85% = $72.75<br>17680 **Extended Medicare Safety Net Cap:** $256.65 |
| | - Where a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in-rooms if:<br><br>(a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and<br><br>(b) the service is not provided to an admitted patient of a hospital; and<br><br>(c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and<br><br>(d) the service is of more than 15 minutes duration<br><br>not being a service associated with a service to which items 2801 – 3000 apply.<br>*(See para T6.3 of explanatory notes to this Category)*<br>**Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65<br>17690 **Extended Medicare Safety Net Cap:** $118.65 |

## GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS

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| 18213 | INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion<br>**Fee:** $88.65 | **Benefit:** 75% = $66.50 | 85% = $75.40 |
| 18216 | 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.)<br>**Fee:** $189.90 | **Benefit:** 75% = $142.45 | 85% = $161.45 |
| 18219 | 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.)<br>**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. | | |
| 18222 | 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<br>*(See para T7.2 of explanatory notes to this Category)*<br>**Fee:** $37.65 | **Benefit:** 75% = $28.25 | 85% = $32.05 |
| 18225 | 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<br>*(See para T7.2 of explanatory notes to this Category)*<br>**Fee:** $50.05 | **Benefit:** 75% = $37.55 | 85% = $42.55 |
| 18226 | **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.<br>*(See para T7.4 of explanatory notes to this Category)*<br>**Fee:** $284.80 | **Benefit:** 75% = $213.60 | 85% = $242.10 |
| 18227 | **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.<br>*(See para T7.4 of explanatory notes to this Category)*<br>**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. | | |
| 18228 | INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance<br>**Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |
| 18230 | INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)<br>**Fee:** $238.45 | **Benefit:** 75% = $178.85 | 85% = $202.70 |
| 18232 | 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.)<br>*(See para T7.3 of explanatory notes to this Category)*<br>**Fee:** $189.90 | **Benefit:** 75% = $142.45 | 85% = $161.45 |
| 18233 | EPIDURAL INJECTION of blood for blood patch (Anaes.)<br>**Fee:** $189.90 | **Benefit:** 75% = $142.45 | 85% = $161.45 |
| 18234 | TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18236 | TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |
| 18238 | FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $37.65 | **Benefit:** 75% = $28.25 | 85% = $32.05 |
| 18240 | RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $93.60 | **Benefit:** 75% = $70.20 | 85% = $79.60 |

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| | GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18242 | **Fee:** $37.65 | **Benefit:** 75% = $28.25 | 85% = $32.05 |
| | VAGUS NERVE, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18244 | **Fee:** $100.80 | **Benefit:** 75% = $75.60 | 85% = $85.70 |
| | GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18246 | **Fee:** $100.80 | **Benefit:** 75% = $75.60 | 85% = $85.70 |
| | PHRENIC NERVE, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18248 | **Fee:** $88.65 | **Benefit:** 75% = $66.50 | 85% = $75.40 |
| | SPINAL ACCESSORY NERVE, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18250 | **Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |
| | CERVICAL PLEXUS, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18252 | **Fee:** $100.80 | **Benefit:** 75% = $75.60 | 85% = $85.70 |
| | BRACHIAL PLEXUS, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18254 | **Fee:** $100.80 | **Benefit:** 75% = $75.60 | 85% = $85.70 |
| | SUPRASCAPULAR NERVE, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18256 | **Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |
| | INTERCOSTAL NERVE (single), injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18258 | **Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |
| | INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent<br>*(See para T7.5 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.)<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18262 | **Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |
| | PUDENDAL NERVE, injection of an anaesthetic agent<br>*(See para T7.5 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<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18266 | **Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |
| | OBTURATOR NERVE, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18268 | **Fee:** $88.65 | **Benefit:** 75% = $66.50 | 85% = $75.40 |
| | FEMORAL NERVE, injection of an anaesthetic agent<br>*(See para T7.5 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<br>*(See para T7.5 of explanatory notes to this Category)* | | |
| 18272 | **Fee:** $62.50 | **Benefit:** 75% = $46.90 | 85% = $53.15 |

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| 18274 | PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $88.65 | **Benefit:** 75% = $66.50 | 85% = $75.40 |
| 18276 | PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18278 | SCIATIC NERVE, injection of an anaesthetic agent<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $88.65 | **Benefit:** 75% = $66.50 | 85% = $75.40 |
| 18280 | SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18282 | CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $100.80 | **Benefit:** 75% = $75.60 | 85% = $85.70 |
| 18284 | STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $147.65 | **Benefit:** 75% = $110.75 | 85% = $125.55 |
| 18286 | LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $147.65 | **Benefit:** 75% = $110.75 | 85% = $125.55 |
| 18288 | COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $147.65 | **Benefit:** 75% = $110.75 | 85% = $125.55 |
| 18290 | CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.)<br>**Fee:** $249.75 | **Benefit:** 75% = $187.35 | 85% = $212.30 |
| 18292 | 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 items 18354, 18356 and 18358 applies (Anaes.)<br>*(See para T7.5 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18294 | COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)<br>**Fee:** $176.00 | **Benefit:** 75% = $132.00 | 85% = $149.60 |
| 18296 | LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)<br>**Fee:** $150.55 | **Benefit:** 75% = $112.95 | 85% = $128.00 |
| 18298 | CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)<br>**Fee:** $176.00 | **Benefit:** 75% = $132.00 | 85% = $149.60 |

## GROUP T11 - BOTULINUM TOXIN INJECTIONS

### BOTULINUM TOXIN

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| 18350 | BOTULINUM TOXIN (Botox), injection of, for hemifacial spasm in a patient 12 years of age or older, including all injections on any one day<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18351 | BOTULINUM TOXIN (Dysport), injection of, for the treatment of hemifacial spasm in a patient 18 years of age or older, including all such injections on any one day<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18352 | BOTULINUM TOXIN (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all injections on any one day<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $249.75 | **Benefit:** 75% = $187.35 | 85% = $212.30 |
| 18354 | BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18356 | BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18358 | BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18360 | BOTULINUM TOXIN (Botox), injection of, for the treatment of focal spasticity in adults, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18361 | Botulinum toxin (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy, in a patient who is at least 2 years but less than 18 years, in association with either:<br>(a) physiotherapy or occupational therapy or both; or<br>(b) electrical stimulation or ultrasound for muscle localisation;<br>including all injections for any or all of the muscles sub-serving one functional activity supplied by one motor nerve — with a maximum of four treatments per patient on any one day, and with a maximum of two treatments per limb (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18362 | BOTULINUM TOXIN (Botox), injection of, for the treatment of severe primary hyperhidrosis of the axillae, including all such injections on any one day (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $246.70 | **Benefit:** 75% = $185.05 | 85% = $209.70 |

| BOTULINUM TOXIN INJECTIONS | | | BOTULINUM TOXIN INJECTIONS |
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| 18364 | BOTULINUM TOXIN (Dysport), injection of, for treatment of spasticity of the arm in adults following a stroke, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18366 | BOTULINUM TOXIN (Botox), injection of, for the treatment of strabismus in children and adults, including all such injections on any one day and associated electromyography (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $156.40 | **Benefit:** 75% = $117.30 | 85% = $132.95 |
| 18368 | BOTULINUM TOXIN (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $267.05 | **Benefit:** 75% = $200.30 | 85% = $227.00 |
| 18370 | BOTULINUM TOXIN (Botox), injection of, for the treatment of blepharospasm in a patient 12 years of age or older, including all such injections on any one day. (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $45.05 | **Benefit:** 75% = $33.80 | 85% = $38.30 |
| 18371 | BOTULINUM TOXIN (Dysport), injection of, for the treatment of blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $45.05 | **Benefit:** 75% = $33.80 | 85% = $38.30 |
| 18372 | BOTULINUM TOXIN (Botox), injection of, for the treatment of bilateral blepharospasm in a patient 12 years of age or older, including all such injections on any one day (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |
| 18373 | BOTULINUM TOXIN (Dysport), injection of, for the treatment of bilateral blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.)<br>*(See para T11.1 of explanatory notes to this Category)*<br>**Fee:** $124.85 | **Benefit:** 75% = $93.65 | 85% = $106.15 |

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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 1 - HEAD* |
| 20100 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20102 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for plastic repair of cleft lip (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20104 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroconvulsive therapy (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20120 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20124 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for otoscopy (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20140 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on eye, not being a service to which another item in this Group applies (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20142 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for lens surgery (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00<br>**Extended Medicare Safety Net Cap:** $95.05 |
| 20143 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for retinal surgery (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20144 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for corneal transplant (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20145 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for vitrectomy (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20146 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of conjunctiva (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20147 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for squint repair (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20148 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for ophthalmoscopy (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20160 | **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)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20162 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on the nose and accessory sinuses (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20164 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of soft tissue of the nose and accessory sinuses (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20170 | **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)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20172 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of cleft palate (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |

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| 20174 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision of retropharyngeal tumour (9 basic units)<br>**Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50 |
| 20176 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical intraoral surgery (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20190 | **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)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20192 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20210 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20212 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for subdural taps (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20214 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for burr holes of the cranium (9 basic units)<br>**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)<br>**Fee:** $396.00 **Benefit:** 75% = $297.00 85% = $336.60 |
| 20220 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for spinal fluid shunt procedures (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20222 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for ablation of an intracranial nerve (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20225 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for all cranial bone procedures (12 basic units)<br>**Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00 |
| 20230 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the head or face (12 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00 |
| | *SUBGROUP 2 - NECK* |
| 20300 | **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)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20305 | **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)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20320 | **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)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20321 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20330 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for laser surgery to the airway (excluding nose and mouth) (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |

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| 20350 | **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)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20352 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for simple ligation of major vessels of neck (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20355 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the neck (12 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00 |
| | *SUBGROUP 3 - THORAX* |
| 20400 | **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)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 20401 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20402 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on breast (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20403 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20404 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for mastectomy (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20405 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on the breast using myocutaneous flaps (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20406 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units)<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |
| 20410 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrical conversion of arrhythmias (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20420 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20440 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the sternum (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20450 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20452 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on clavicle, scapula or sternum (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20470 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20472 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoplasty (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20474 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on chest wall (13 basic units)<br>*(See para T10.22 of explanatory notes to this Category)*<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |

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| 20475 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| | *SUBGROUP 4 - INTRATHORACIC* |
| 20500 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the oesophagus (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20520 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20522 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for needle biopsy of pleura (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20524 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for pneumocentesis (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20526 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoscopy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20528 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for mediastinoscopy (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20540 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units)<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |
| 20542 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary decortication (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20546 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary resection with thoracoplasty (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20548 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for intrathoracic repair of trauma to trachea and bronchi (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20560 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the heart, pericardium or great vessels of chest (20 basic units)<br>**Fee:** $396.00 **Benefit:** 75% = $297.00 85% = $336.60 |
| | *SUBGROUP 5 - SPINE AND SPINAL CORD* |
| 20600 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20604 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for posterior cervical laminectomy with the patient in the sitting position (13 basic units)<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |
| 20620 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20622 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracolumbar sympathectomy (13 basic units)<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |
| 20630 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20632 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar sympathectomy (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |

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| 20634 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for chemonucleolysis (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20670 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive spine and/or spinal cord procedures (13 basic units)<br>*(See para T10.23 of explanatory notes to this Category)*<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |
| 20680 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for manipulation of spine when performed in the operating theatre of a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 20690 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| | *SUBGROUP 6 - UPPER ABDOMEN* |
| 20700 | **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)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 20702 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous liver biopsy (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20703 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20704 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20705 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopy procedures (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20706 | **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)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20730 | **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)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20740 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20745 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20750 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in upper abdomen, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20752 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional hernia and/or wound dehiscence (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20754 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on an omphalocele (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20756 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for transabdominal repair of diaphragmatic hernia (9 basic units)<br>**Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50 |

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| 20770 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major upper abdominal blood vessels (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20790 | **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)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20791 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for gastric reduction or gastroplasty for the treatment of morbid obesity (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20792 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial hepatectomy (excluding liver biopsy) (13 basic units)<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |
| 20793 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for extended or trisegmental hepatectomy (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20794 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for pancreatectomy, partial or total (12 basic units)<br>**Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00 |
| 20798 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the upper abdomen (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20799 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| | *SUBGROUP 7 - LOWER ABDOMEN* |
| 20800 | **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)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 20802 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for lipectomy of the lower abdomen (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20803 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20804 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20805 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopic procedures (6 basic units)<br>**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)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20810 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower intestinal endoscopic procedures (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20815 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for extracorporeal shock wave lithotripsy to urinary tract (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20820 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20830 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |

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| 20832 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20840 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures within the peritoneal cavity in lower abdomen including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20841 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20842 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for amniocentesis (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20844 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20845 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical prostatectomy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20846 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical hysterectomy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20847 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for ovarian malignancy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20848 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for pelvic exenteration (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20850 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarean section (12 basic units)<br>**Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00 |
| 20855 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarean hysterectomy or hysterectomy within 24 hours of delivery. (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20860 | **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)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20862 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal procedures, including upper 1/3 of ureter (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20863 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for nephrectomy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20864 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for total cystectomy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20866 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for adrenalectomy (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20867 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the lower abdomen (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20868 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal transplantation (donor or recipient) (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20880 | **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)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 20882 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for inferior vena cava ligation (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |

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| 20884 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous umbrella insertion (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20886 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| | *SUBGROUP 8 - PERINEUM* |
| 20900 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the perineum (including biopsy of male genital system), not being a service to which another item in this Subgroup applies (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 20902 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for anorectal procedures (including endoscopy and/or biopsy) (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20904 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20905 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the perineum (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20906 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for vulvectomy (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20910 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20911 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for endoscopic ureteroscopic surgery including laser procedures (5 basic units)<br>*(See para T10.29 of explanatory notes to this Category)*<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20912 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of bladder tumour(s) (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20914 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of prostate (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20916 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for bleeding post-transurethral resection (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 20920 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on male external genitalia, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20924 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on undescended testis, unilateral or bilateral (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20926 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, inguinal approach (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20928 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, abdominal approach (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20930 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for orchiopexy, unilateral or bilateral (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20932 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |

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| 20934 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20936 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20938 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for insertion of penile prosthesis (4 basic units)<br>**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 labia, vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20942 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20943 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for transvaginal assisted reproductive services (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20944 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal hysterectomy (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 20946 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal delivery (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 20948 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for purse string ligation of cervix, or removal of purse string ligature (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20950 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for culdoscopy (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20952 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for hysteroscopy (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20953 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for endometrial ablation or resection in association with hysteroscopy (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20954 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for correction of inverted uterus (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 20956 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for evacuation of retained products of conception, as a complication of confinement (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 20958 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 20960 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| | *SUBGROUP 9 - PELVIS (EXCEPT HIP)* |
| 21100 | **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)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21110 | **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)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |

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| 21112 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21114 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21116 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow harvesting from the pelvis (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21120 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the bony pelvis (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21130 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for body cast application or revision when performed in the operating theatre of a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21140 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for interpelviabdominal (hind-quarter) amputation (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 21150 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21155 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21160 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21170 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving symphysis pubis or sacroiliac joint (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| | *SUBGROUP 10 - UPPER LEG (EXCEPT KNEE)* |
| 21195 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21199 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21200 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21202 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the hip joint (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21210 | **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)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21212 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for hip disarticulation (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21214 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for total hip replacement or revision (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |

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| 21216 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral total hip replacement (14 basic units)<br>**Fee:** $277.20 **Benefit:** 75% = $207.90 85% = $235.65 |
| 21220 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21230 | **INITIATION OF 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)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21232 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for above knee amputation (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21234 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of the upper 2/3 of femur (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21260 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures involving veins of upper leg, including exploration (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21270 | **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)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21272 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery ligation (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21274 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery embolectomy (6 basic units)<br>*(See para T10.24 of explanatory notes to this Category)*<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21275 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper leg (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21280 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper leg (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| | *SUBGROUP 11 - KNEE AND POPLITEAL AREA* |
| 21300 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21321 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21340 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21360 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on lower 1/3 of femur (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21380 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21382 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of knee joint (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21390 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |

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| 21392 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21400 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21402 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for knee replacement (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 21403 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral knee replacement (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21404 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for disarticulation of knee (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21420 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21430 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21432 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of arteriovenous fistula of knee or popliteal area (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21440 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21445 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| | *SUBGROUP 12 - LOWER LEG (BELOW KNEE)* |
| 21460 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21461 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21462 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower leg, ankle, or foot (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21464 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedure of ankle joint (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21472 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of Achilles tendon (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21474 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for gastrocnemius recession (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21480 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21482 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of bone involving lower leg, ankle or foot (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |

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| 21484 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for osteotomy or osteoplasty of tibia or fibula (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21486 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for total ankle replacement (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 21490 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21500 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21502 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of the lower leg (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21520 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21522 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for venous thrombectomy of the lower leg (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21530 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of lower leg, ankle or foot (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 21532 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of toe (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21535 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the lower leg (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| | *SUBGROUP 13 - SHOULDER AND AXILLA* |
| 21600 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21610 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21620 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21622 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of shoulder joint (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21630 | **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)<br>**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)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21634 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder disarticulation (9 basic units)<br>**Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50 |
| 21636 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for interthoracoscapular (forequarter) amputation (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |

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| 21638 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for total shoulder replacement (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21650 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21652 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures for axillary-brachial aneurysm (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21654 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for bypass graft of arteries of shoulder or axilla (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21656 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for axillary-femoral bypass graft (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21670 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of shoulder or axilla (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21680 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21682 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder spica application when undertaken in a hospital (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21685 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| | *SUBGROUP 14 - UPPER ARM AND ELBOW* |
| 21700 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21710 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21712 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open tenotomy of the upper arm or elbow (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21714 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenoplasty of the upper arm or elbow (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21716 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenodesis for rupture of long tendon of biceps (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21730 | **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)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21732 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of elbow joint (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21740 | **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)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21756 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on the upper arm or elbow (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21760 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for total elbow replacement (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |

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| 21770 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21772 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of arteries of the upper arm (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21780 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21785 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21790 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper arm (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| | *SUBGROUP 15 - FOREARM WRIST AND HAND* |
| 21800 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21810 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21820 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21830 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21832 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for total wrist replacement (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 21834 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the wrist joint (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21840 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21842 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of artery of forearm, wrist or hand (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21850 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21860 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21865 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units)<br>*(See para T10.28 of explanatory notes to this Category)*<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21870 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of forearm, wrist or hand (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |

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| 21872 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of a finger (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| | *SUBGROUP 16 - ANAESTHESIA FOR BURNS* |
| 21878 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21879 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting,where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21880 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units)<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 21881 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units)<br>**Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50 |
| 21882 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units)<br>**Fee:** $217.80 **Benefit:** 75% = $163.35 85% = $185.15 |
| 21883 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units)<br>**Fee:** $257.40 **Benefit:** 75% = $193.05 85% = $218.80 |
| 21884 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 21885 | **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)<br>**Fee:** $336.60 **Benefit:** 75% = $252.45 85% = $286.15 |
| 21886 | **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)<br>**Fee:** $376.20 **Benefit:** 75% = $282.15 85% = $319.80 |
| 21887 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units)<br>**Fee:** $415.80 **Benefit:** 75% = $311.85 85% = $353.45 |
| | *SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES* |
| 21900 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for hysterosalpingography (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21906 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: lumbar or thoracic (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21908 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: cervical (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21910 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: posterior fossa (9 basic units)<br>**Fee:** $178.20 **Benefit:** 75% = $133.65 85% = $151.50 |
| 21912 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: lumbar or thoracic (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |

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| 21914 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: cervical (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21915 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral arteriogram (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21916 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for arteriograms: cerebral, carotid or vertebral (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21918 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for retrograde arteriogram: brachial or femoral (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21922 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units)<br>**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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21926 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for fluoroscopy (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21927 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for barium enema or other opaque study of the small bowel (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21930 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for bronchography (6 basic units)<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21935 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for phlebography (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21936 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for heart, 2 dimensional real time transoesophageal examination (6 basic units)<br>*(See para T10.26 of explanatory notes to this Category)*<br>**Fee:** $118.80 **Benefit:** 75% = $89.10 85% = $101.00 |
| 21939 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral venous cannulation (3 basic units)<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21941 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units)<br>*(See para T10.25 of explanatory notes to this Category)*<br>**Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85 |
| 21942 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac electrophysiological procedures including radio frequency ablation (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21943 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21945 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar puncture, cisternal puncture, or epidural injection (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21949 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for harvesting of bone marrow for the purpose of transplantation (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21952 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for muscle biopsy for malignant hyperpyrexia (10 basic units)<br>**Fee:** $198.00 **Benefit:** 75% = $148.50 85% = $168.30 |
| 21955 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroencephalography (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |

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| 21959 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for brain stem evoked response audiometry (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21962 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21965 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** as a therapeutic procedure **where it can be demonstrated that there is a clinical need for anaesthesia, not for the treatment of headache of any etiology** (5 basic units)<br>*(See para T10.11 of explanatory notes to this Category)*<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21969 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units)<br>**Fee:** $158.40 **Benefit:** 75% = $118.80 85% = $134.65 |
| 21970 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units)<br>**Fee:** $297.00 **Benefit:** 75% = $222.75 85% = $252.45 |
| 21973 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for brachytherapy using radioactive sealed sources (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21976 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for therapeutic nuclear medicine (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21980 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for radiotherapy (5 basic units)<br>**Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15 |
| 21981 | **ANAESTHETIC AGENT ALLERGY TESTING**, using skin sensitivity methods in a patient with a history of prior anaphylactic or anaphylactoid reaction or cardiovascular collapse associated with the management of anaesthesia agents (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| | *SUBGROUP 18 - MISCELLANEOUS* |
| 21990 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** when no procedure ensues (3 basic units)<br>*(See para T10.12 of explanatory notes to this Category)*<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| 21992 | **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)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 21997 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies **where it can be demonstrated that there is a clinical need for anaesthesia** (4 basic units)<br>*(See para T10.13 of explanatory notes to this Category)*<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| | *SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES* |
| 22001 | **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)<br>*(See para T10.8 of explanatory notes to this Category)*<br>**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)<br>*(See para T10.8 of explanatory notes to this Category)*<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |
| 22007 | **ENDOTRACHEAL INTUBATION** with flexible fibreoptic scope associated with difficult airway **when performed in association with the administration of anaesthesia** (4 basic units)<br>**Fee:** $79.20 **Benefit:** 75% = $59.40 85% = $67.35 |

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| 22008 | **DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER,** insertion of when **performed in association with the administration of anaesthesia** (4 basic units)<br>**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 association with the administration of anaesthesia** (3 basic units)<br>*(See para T10.8 of explanatory notes to this Category)*<br>**Fee:** $59.40 | **Benefit:** 75% = $44.55 | 85% = $50.50 |
| 22014 | **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 association with the administration of anaesthesia relating to another discrete operation on the same day** (3 basic units)<br>*(See para T10.8 of explanatory notes to this Category)*<br>**Fee:** $59.40 | **Benefit:** 75% = $44.55 | 85% = $50.50 |
| 22015 | **RIGHT HEART BALLOON CATHETER,** insertion of, including pulmonary wedge pressure and cardiac output measurement, **when performed in association with the administration of anaesthesia** (6 basic units)<br>*(See para T10.8 of explanatory notes to this Category)*<br>**Fee:** $118.80 | **Benefit:** 75% = $89.10 | 85% = $101.00 |
| 22018 | **MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM**, using measurements of parameters, including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood and incorporating serial arterial blood gas analysis and a written record of the results, when performed in association with the administration of anaesthesia, not being a service associated with a service to which item 11503 applies (7 basic units)<br>**Fee:** $138.60 | **Benefit:** 75% = $103.95 | 85% = $117.85 |
| 22020 | **CENTRAL VEIN CATHETERISATION** by percutaneous or open exposure, not being a service to which item 13318 applies, **when performed in association with the administration of anaesthesia** (4 basic units)<br>*(See para T1.6 and T10.8 of explanatory notes to this Category)*<br>**Fee:** $79.20 | **Benefit:** 75% = $59.40 | 85% = $67.35 |
| 22025 | **INTRAARTERIAL CANNULATION when performed in association with the administration of anaesthesia** (4 basic units)<br>*(See para T10.8 of explanatory notes to this Category)*<br>**Fee:** $79.20 | **Benefit:** 75% = $59.40 | 85% = $67.35 |
| 22031 | **INTRATHECAL or EPIDURAL INJECTION** (initial) of a therapeutic substance or substances, with or without insertion of a catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22036 applies (5 basic units)<br>*(See para T10.19 of explanatory notes to this Category)*<br>**Fee:** $99.00 | **Benefit:** 75% = $74.25 | 85% = $84.15 |
| 22036 | **INTRATHECAL or EPIDURAL INJECTION** (subsequent) of a therapeutic substance or substances, using an in-situ catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units)<br>*(See para T10.20 of explanatory notes to this Category)*<br>**Fee:** $59.40 | **Benefit:** 75% = $44.55 | 85% = $50.50 |
| 22040 | **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)<br>*(See para T10.17 and T10.21 of explanatory notes to this Category)*<br>**Fee:** $39.60 | **Benefit:** 75% = $29.70 | 85% = $33.70 |
| 22045 | **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)<br>*(See para T10.17 and T10.21 of explanatory notes to this Category)*<br>**Fee:** $59.40 | **Benefit:** 75% = $44.55 | 85% = $50.50 |
| 22050 | **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)<br>*(See para T10.17 and T10.21 of explanatory notes to this Category)*<br>**Fee:** $39.60 | **Benefit:** 75% = $29.70 | 85% = $33.70 |

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| 22051 | **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)<br>**Fee:** $178.20 | **Benefit:** 75% = $133.65 | 85% = $151.50 |
| 22055 | **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)<br>*(See para T10.10 of explanatory notes to this Category)*<br>**Fee:** $237.60 | **Benefit:** 75% = $178.20 | 85% = $202.00 |
| 22060 | **WHOLE BODY PERFUSION, CARDIAC BYPASS**, using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (20 basic units)<br>*(See para T10.10 of explanatory notes to this Category)*<br>**Fee:** $396.00 | **Benefit:** 75% = $297.00 | 85% = $336.60 |
| 22065 | **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)<br>*(See para T10.10 of explanatory notes to this Category)*<br>**Fee:** $99.00 | **Benefit:** 75% = $74.25 | 85% = $84.15 |
| 22070 | **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)<br>*(See para T10.10 of explanatory notes to this Category)*<br>**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 anaesthesia to which an item in Subgroup 21 applies (15 basic units)<br>*(See para T10.10 of explanatory notes to this Category)*<br>**Fee:** $297.00 | **Benefit:** 75% = $222.75 | 85% = $252.45 |
| | *SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE* | | |
| 22900 | **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)<br>*(See para T10.14 of explanatory notes to this Category)*<br>**Fee:** $118.80 | **Benefit:** 75% = $89.10 | 85% = $101.00 |
| 22905 | **INITIATION OF MANAGEMENT OF ANAESTHESIA** for restorative dental work (6 basic units)<br>*(See para T10.14 of explanatory notes to this Category)*<br>**Fee:** $118.80 | **Benefit:** 75% = $89.10 | 85% = $101.00 |
| | *SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS* | | |
| 23010 | ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA<br>(a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or<br>(b) perfusion performed in association with item 22060; or<br>(c) for assistance at anaesthesia performed in association with items 25200 to 25205<br><br>For a period of:<br><br>(FIFTEEN MINUTES OR LESS) (1 basic units)<br>*(See para T10.3 of explanatory notes to this Category)*<br>**Fee:** $19.80 | **Benefit:** 75% = $14.85 | 85% = $16.85 |
| 23021 | 16 MINUTES TO 20 MINUTES (2 basic units)<br>**Fee:** $39.60 | **Benefit:** 75% = $29.70 | 85% = $33.70 |
| 23022 | 21 MINUTES TO 25 MINUTES (2 basic units)<br>**Fee:** $39.60 | **Benefit:** 75% = $29.70 | 85% = $33.70 |
| 23023 | 26 MINUTES TO 30 MINUTES (2 basic units)<br>**Fee:** $39.60 | **Benefit:** 75% = $29.70 | 85% = $33.70 |
| 23031 | 31 MINUTES TO 35 MINUTES (3 basic units)<br>**Fee:** $59.40 | **Benefit:** 75% = $44.55 | 85% = $50.50 |

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| 23032 | 36 MINUTES TO 40 MINUTES (3 basic units)<br>**Fee:** $59.40 | **Benefit:** 75% = $44.55 | 85% = $50.50 |
| 23033 | 41 MINUTES TO 45 MINUTES (3 basic units)<br>**Fee:** $59.40 | **Benefit:** 75% = $44.55 | 85% = $50.50 |
| 23041 | 46 MINUTES TO 50 MINUTES (4 basic units)<br>**Fee:** $79.20 | **Benefit:** 75% = $59.40 | 85% = $67.35 |
| 23042 | 51 MINUTES TO 55 MINUTES (4 basic units)<br>**Fee:** $79.20 | **Benefit:** 75% = $59.40 | 85% = $67.35 |
| 23043 | 56 MINUTES TO 1:00 HOUR (4 basic units)<br>**Fee:** $79.20 | **Benefit:** 75% = $59.40 | 85% = $67.35 |
| 23051 | 1:01 HOURS TO 1:05 HOURS (5 basic units)<br>**Fee:** $99.00 | **Benefit:** 75% = $74.25 | 85% = $84.15 |
| 23052 | 1:06 HOURS TO 1:10 HOURS (5 basic units)<br>**Fee:** $99.00 | **Benefit:** 75% = $74.25 | 85% = $84.15 |
| 23053 | 1:11 HOURS TO 1:15 HOURS (5 basic units)<br>**Fee:** $99.00 | **Benefit:** 75% = $74.25 | 85% = $84.15 |
| 23061 | 1:16 HOURS TO 1:20 HOURS (6 basic units)<br>**Fee:** $118.80 | **Benefit:** 75% = $89.10 | 85% = $101.00 |
| 23062 | 1:21 HOURS TO 1:25 HOURS (6 basic units)<br>**Fee:** $118.80 | **Benefit:** 75% = $89.10 | 85% = $101.00 |
| 23063 | 1:26 HOURS TO 1:30 HOURS (6 basic units)<br>**Fee:** $118.80 | **Benefit:** 75% = $89.10 | 85% = $101.00 |
| 23071 | 1:31 HOURS TO 1:35 HOURS (7 basic units)<br>**Fee:** $138.60 | **Benefit:** 75% = $103.95 | 85% = $117.85 |
| 23072 | 1:36 HOURS TO 1:40 HOURS (7 basic units)<br>**Fee:** $138.60 | **Benefit:** 75% = $103.95 | 85% = $117.85 |
| 23073 | 1:41 HOURS TO 1:45 HOURS (7 basic units)<br>**Fee:** $138.60 | **Benefit:** 75% = $103.95 | 85% = $117.85 |
| 23081 | 1:46 HOURS TO 1:50 HOURS (8 basic units)<br>**Fee:** $158.40 | **Benefit:** 75% = $118.80 | 85% = $134.65 |
| 23082 | 1:51 HOURS TO 1:55 HOURS (8 basic units)<br>**Fee:** $158.40 | **Benefit:** 75% = $118.80 | 85% = $134.65 |
| 23083 | 1:56 HOURS TO 2:00 HOURS (8 basic units)<br>**Fee:** $158.40 | **Benefit:** 75% = $118.80 | 85% = $134.65 |
| 23091 | 2:01 HOURS TO 2:10 HOURS (9 basic units)<br>**Fee:** $178.20 | **Benefit:** 75% = $133.65 | 85% = $151.50 |
| 23101 | 2:11 HOURS TO 2:20 HOURS (10 basic units)<br>**Fee:** $198.00 | **Benefit:** 75% = $148.50 | 85% = $168.30 |
| 23111 | 2:21 HOURS TO 2:30 HOURS (11 basic units)<br>**Fee:** $217.80 | **Benefit:** 75% = $163.35 | 85% = $185.15 |
| 23112 | 2:31 HOURS TO 2:40 HOURS (12 basic units)<br>**Fee:** $237.60 | **Benefit:** 75% = $178.20 | 85% = $202.00 |
| 23113 | 2:41 HOURS TO 2:50 HOURS (13 basic units)<br>**Fee:** $257.40 | **Benefit:** 75% = $193.05 | 85% = $218.80 |

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| 23114 | 2:51 HOURS TO 3:00 HOURS (14 basic units)<br>**Fee:** $277.20 | **Benefit:** 75% = $207.90 | 85% = $235.65 |
| 23115 | 3:01 HOURS TO 3:10 HOURS (15 basic units)<br>**Fee:** $297.00 | **Benefit:** 75% = $222.75 | 85% = $252.45 |
| 23116 | 3:11 HOURS TO 3:20 HOURS (16 basic units)<br>**Fee:** $316.80 | **Benefit:** 75% = $237.60 | 85% = $269.30 |
| 23117 | 3:21 HOURS TO 3:30 HOURS (17 basic units)<br>**Fee:** $336.60 | **Benefit:** 75% = $252.45 | 85% = $286.15 |
| 23118 | 3:31 HOURS TO 3:40 HOURS (18 basic units)<br>**Fee:** $356.40 | **Benefit:** 75% = $267.30 | 85% = $302.95 |
| 23119 | 3:41 HOURS TO 3:50 HOURS (19 basic units)<br>**Fee:** $376.20 | **Benefit:** 75% = $282.15 | 85% = $319.80 |
| 23121 | 3:51 HOURS TO 4:00 HOURS (20 basic units)<br>**Fee:** $396.00 | **Benefit:** 75% = $297.00 | 85% = $336.60 |
| 23170 | 4:01 HOURS TO 4:10 HOURS (21 basic units)<br>**Fee:** $415.80 | **Benefit:** 75% = $311.85 | 85% = $353.45 |
| 23180 | 4:11 HOURS TO 4:20 HOURS (22 basic units)<br>**Fee:** $435.60 | **Benefit:** 75% = $326.70 | 85% = $370.30 |
| 23190 | 4:21 HOURS TO 4:30 HOURS (23 basic units)<br>**Fee:** $455.40 | **Benefit:** 75% = $341.55 | 85% = $387.10 |
| 23200 | 4:31 HOURS TO 4:40 HOURS (24 basic units)<br>**Fee:** $475.20 | **Benefit:** 75% = $356.40 | 85% = $403.95 |
| 23210 | 4:41 HOURS TO 4:50 HOURS (25 basic units)<br>**Fee:** $495.00 | **Benefit:** 75% = $371.25 | 85% = $420.75 |
| 23220 | 4:51 HOURS TO 5:00 HOURS (26 basic units)<br>**Fee:** $514.80 | **Benefit:** 75% = $386.10 | 85% = $440.30 |
| 23230 | 5:01 HOURS TO 5:10 HOURS (27 basic units)<br>**Fee:** $534.60 | **Benefit:** 75% = $400.95 | 85% = $460.10 |
| 23240 | 5:11 HOURS TO 5:20 HOURS (28 basic units)<br>**Fee:** $554.40 | **Benefit:** 75% = $415.80 | 85% = $479.90 |
| 23250 | 5:21 HOURS TO 5:30 HOURS (29 basic units)<br>**Fee:** $574.20 | **Benefit:** 75% = $430.65 | 85% = $499.70 |
| 23260 | 5:31 HOURS TO 5:40 HOURS (30 basic units)<br>**Fee:** $594.00 | **Benefit:** 75% = $445.50 | 85% = $519.50 |
| 23270 | 5:41 HOURS TO 5:50 HOURS (31 basic units)<br>**Fee:** $613.80 | **Benefit:** 75% = $460.35 | 85% = $539.30 |
| 23280 | (5:51 HOURS TO 6:00 HOURS (32 basic units)<br>**Fee:** $633.60 | **Benefit:** 75% = $475.20 | 85% = $559.10 |
| 23290 | 6:01 HOURS TO 6:10 HOURS (33 basic units)<br>**Fee:** $653.40 | **Benefit:** 75% = $490.05 | 85% = $578.90 |
| 23300 | 6:11 HOURS TO 6:20 HOURS (34 basic units)<br>**Fee:** $673.20 | **Benefit:** 75% = $504.90 | 85% = $598.70 |
| 23310 | 6:21 HOURS TO 6:30 HOURS (35 basic units)<br>**Fee:** $693.00 | **Benefit:** 75% = $519.75 | 85% = $618.50 |

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| 23320 | 6:31 HOURS TO 6:40 HOURS (36 basic units)<br>**Fee:** $712.80 | **Benefit:** 75% = $534.60 | 85% = $638.30 |
| 23330 | 6:41 HOURS TO 6:50 HOURS (37 basic units)<br>**Fee:** $732.60 | **Benefit:** 75% = $549.45 | 85% = $658.10 |
| 23340 | 6:51 HOURS TO 7:00 HOURS (38 basic units)<br>**Fee:** $752.40 | **Benefit:** 75% = $564.30 | 85% = $677.90 |
| 23350 | 7:01 HOURS TO 7:10 HOURS (39 basic units)<br>**Fee:** $772.20 | **Benefit:** 75% = $579.15 | 85% = $697.70 |
| 23360 | 7:11 HOURS TO 7:20 HOURS (40 basic units)<br>**Fee:** $792.00 | **Benefit:** 75% = $594.00 | 85% = $717.50 |
| 23370 | 7:21 HOURS TO 7:30 HOURS (41 basic units)<br>**Fee:** $811.80 | **Benefit:** 75% = $608.85 | 85% = $737.30 |
| 23380 | 7:31 HOURS TO 7:40 HOURS (42 basic units)<br>**Fee:** $831.60 | **Benefit:** 75% = $623.70 | 85% = $757.10 |
| 23390 | 7:41 HOURS TO 7:50 HOURS (43 basic units)<br>**Fee:** $851.40 | **Benefit:** 75% = $638.55 | 85% = $776.90 |
| 23400 | 7:51 HOURS TO 8:00 HOURS (44 basic units)<br>**Fee:** $871.20 | **Benefit:** 75% = $653.40 | 85% = $796.70 |
| 23410 | 8:01 HOURS TO 8:10 HOURS (45 basic units)<br>**Fee:** $891.00 | **Benefit:** 75% = $668.25 | 85% = $816.50 |
| 23420 | 8:11 HOURS TO 8:20 HOURS (46 basic units)<br>**Fee:** $910.80 | **Benefit:** 75% = $683.10 | 85% = $836.30 |
| 23430 | 8:21 HOURS TO 8:30 HOURS (47 basic units)<br>**Fee:** $930.60 | **Benefit:** 75% = $697.95 | 85% = $856.10 |
| 23440 | 8:31 HOURS TO 8:40 HOURS (48 basic units)<br>**Fee:** $950.40 | **Benefit:** 75% = $712.80 | 85% = $875.90 |
| 23450 | 8:41 HOURS TO 8:50 HOURS (49 basic units)<br>**Fee:** $970.20 | **Benefit:** 75% = $727.65 | 85% = $895.70 |
| 23460 | 8:51 HOURS TO 9:00 HOURS (50 basic units)<br>**Fee:** $990.00 | **Benefit:** 75% = $742.50 | 85% = $915.50 |
| 23470 | 9:01 HOURS TO 9:10 HOURS (51 basic units)<br>**Fee:** $1,009.80 | **Benefit:** 75% = $757.35 | 85% = $935.30 |
| 23480 | 9:11 HOURS TO 9:20 HOURS (52 basic units)<br>**Fee:** $1,029.60 | **Benefit:** 75% = $772.20 | 85% = $955.10 |
| 23490 | 9:21 HOURS TO 9:30 HOURS (53 basic units)<br>**Fee:** $1,049.40 | **Benefit:** 75% = $787.05 | 85% = $974.90 |
| 23500 | 9:31 HOURS TO 9:40 HOURS (54 basic units)<br>**Fee:** $1,069.20 | **Benefit:** 75% = $801.90 | 85% = $994.70 |
| 23510 | 9:41 HOURS TO 9:50 HOURS (55 basic units)<br>**Fee:** $1,089.00 | **Benefit:** 75% = $816.75 | 85% = $1,014.50 |
| 23520 | 9:51 HOURS TO 10:00 HOURS (56 basic units)<br>**Fee:** $1,108.80 | **Benefit:** 75% = $831.60 | 85% = $1,034.30 |
| 23530 | 10:01 HOURS TO 10:10 HOURS (57 basic units)<br>**Fee:** $1,128.60 | **Benefit:** 75% = $846.45 | 85% = $1,054.10 |

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| | 10:11 HOURS TO 10:20 HOURS (58 basic units) | | |
| 23540 | **Fee:** $1,148.40 | **Benefit:** 75% = $861.30 | 85% = $1,073.90 |
| | 10:21 HOURS TO 10:30 HOURS (59 basic units) | | |
| 23550 | **Fee:** $1,168.20 | **Benefit:** 75% = $876.15 | 85% = $1,093.70 |
| | 10:31 HOURS TO 10:40 HOURS (60 basic units) | | |
| 23560 | **Fee:** $1,188.00 | **Benefit:** 75% = $891.00 | 85% = $1,113.50 |
| | 10:41 HOURS TO 10:50 HOURS (61 basic units) | | |
| 23570 | **Fee:** $1,207.80 | **Benefit:** 75% = $905.85 | 85% = $1,133.30 |
| | 10:51 HOURS TO 11:00 HOURS (62 basic units) | | |
| 23580 | **Fee:** $1,227.60 | **Benefit:** 75% = $920.70 | 85% = $1,153.10 |
| | 11:01 HOURS TO 11:10 HOURS (63 basic units) | | |
| 23590 | **Fee:** $1,247.40 | **Benefit:** 75% = $935.55 | 85% = $1,172.90 |
| | 11:11 HOURS TO 11:20 HOURS (64 basic units) | | |
| 23600 | **Fee:** $1,267.20 | **Benefit:** 75% = $950.40 | 85% = $1,192.70 |
| | 11:21 HOURS TO 11:30 HOURS (65 basic units) | | |
| 23610 | **Fee:** $1,287.00 | **Benefit:** 75% = $965.25 | 85% = $1,212.50 |
| | 11:31 HOURS TO 11:40 HOURS (66 basic units) | | |
| 23620 | **Fee:** $1,306.80 | **Benefit:** 75% = $980.10 | 85% = $1,232.30 |
| | 11:41 HOURS TO 11:50 HOURS (67 basic units) | | |
| 23630 | **Fee:** $1,326.60 | **Benefit:** 75% = $994.95 | 85% = $1,252.10 |
| | 11:51 HOURS TO 12:00 HOURS (68 basic units) | | |
| 23640 | **Fee:** $1,346.40 | **Benefit:** 75% = $1,009.80 | 85% = $1,271.90 |
| | 12:01 HOURS TO 12:10 HOURS (69 basic units) | | |
| 23650 | **Fee:** $1,366.20 | **Benefit:** 75% = $1,024.65 | 85% = $1,291.70 |
| | 12:11 HOURS TO 12:20 HOURS (70 basic units) | | |
| 23660 | **Fee:** $1,386.00 | **Benefit:** 75% = $1,039.50 | 85% = $1,311.50 |
| | 12:21 HOURS TO 12:30 HOURS (71 basic units) | | |
| 23670 | **Fee:** $1,405.80 | **Benefit:** 75% = $1,054.35 | 85% = $1,331.30 |
| | 12:31 HOURS TO 12:40 HOURS (72 basic units) | | |
| 23680 | **Fee:** $1,425.60 | **Benefit:** 75% = $1,069.20 | 85% = $1,351.10 |
| | 12:41 HOURS TO 12:50 HOURS (73 basic units) | | |
| 23690 | **Fee:** $1,445.40 | **Benefit:** 75% = $1,084.05 | 85% = $1,370.90 |
| | 12:51 HOURS TO 13:00 HOURS (74 basic units) | | |
| 23700 | **Fee:** $1,465.20 | **Benefit:** 75% = $1,098.90 | 85% = $1,390.70 |
| | 13:01 HOURS TO 13:10 HOURS (75 basic units) | | |
| 23710 | **Fee:** $1,485.00 | **Benefit:** 75% = $1,113.75 | 85% = $1,410.50 |
| | 13:11 HOURS TO 13:20 HOURS (76 basic units) | | |
| 23720 | **Fee:** $1,504.80 | **Benefit:** 75% = $1,128.60 | 85% = $1,430.30 |
| | 13:21 HOURS TO 13:30 HOURS (77 basic units) | | |
| 23730 | **Fee:** $1,524.60 | **Benefit:** 75% = $1,143.45 | 85% = $1,450.10 |
| | 13:31 HOURS TO 13:40 HOURS (78 basic units) | | |
| 23740 | **Fee:** $1,544.40 | **Benefit:** 75% = $1,158.30 | 85% = $1,469.90 |
| | 13:41 HOURS TO 13:50 HOURS (79 basic units) | | |
| 23750 | **Fee:** $1,564.20 | **Benefit:** 75% = $1,173.15 | 85% = $1,489.70 |

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| | 13:51 HOURS TO 14:00 HOURS (80 basic units) | | |
| 23760 | **Fee:** $1,584.00 | **Benefit:** 75% = $1,188.00 | 85% = $1,509.50 |
| | 14:01 HOURS TO 14:10 HOURS (81 basic units) | | |
| 23770 | **Fee:** $1,603.80 | **Benefit:** 75% = $1,202.85 | 85% = $1,529.30 |
| | 14:11 HOURS TO 14:20 HOURS (82 basic units) | | |
| 23780 | **Fee:** $1,623.60 | **Benefit:** 75% = $1,217.70 | 85% = $1,549.10 |
| | 14:21 HOURS TO 14:30 HOURS (83 basic units) | | |
| 23790 | **Fee:** $1,643.40 | **Benefit:** 75% = $1,232.55 | 85% = $1,568.90 |
| | 14:31 HOURS TO 14:40 HOURS (84 basic units) | | |
| 23800 | **Fee:** $1,663.20 | **Benefit:** 75% = $1,247.40 | 85% = $1,588.70 |
| | 14:41 HOURS TO 14:50 HOURS (85 basic units) | | |
| 23810 | **Fee:** $1,683.00 | **Benefit:** 75% = $1,262.25 | 85% = $1,608.50 |
| | 14:51 HOURS TO 15:00 HOURS (86 basic units) | | |
| 23820 | **Fee:** $1,702.80 | **Benefit:** 75% = $1,277.10 | 85% = $1,628.30 |
| | 15:01 HOURS TO 15:10 HOURS (87 basic units) | | |
| 23830 | **Fee:** $1,722.60 | **Benefit:** 75% = $1,291.95 | 85% = $1,648.10 |
| | 15:11 HOURS TO 15:20 HOURS (88 basic units) | | |
| 23840 | **Fee:** $1,742.40 | **Benefit:** 75% = $1,306.80 | 85% = $1,667.90 |
| | 15:21 HOURS TO 15:30 HOURS (89 basic units) | | |
| 23850 | **Fee:** $1,762.20 | **Benefit:** 75% = $1,321.65 | 85% = $1,687.70 |
| | 15:31 HOURS TO 15:40 HOURS (90 basic units) | | |
| 23860 | **Fee:** $1,782.00 | **Benefit:** 75% = $1,336.50 | 85% = $1,707.50 |
| | 15:41 HOURS TO 15:50 HOURS (91 basic units) | | |
| 23870 | **Fee:** $1,801.80 | **Benefit:** 75% = $1,351.35 | 85% = $1,727.30 |
| | 15:51 HOURS TO 16:00 HOURS (92 basic units) | | |
| 23880 | **Fee:** $1,821.60 | **Benefit:** 75% = $1,366.20 | 85% = $1,747.10 |
| | 16:01 HOURS TO 16:10 HOURS (93 basic units) | | |
| 23890 | **Fee:** $1,841.40 | **Benefit:** 75% = $1,381.05 | 85% = $1,766.90 |
| | 16:11 HOURS TO 16:20 HOURS (94 basic units) | | |
| 23900 | **Fee:** $1,861.20 | **Benefit:** 75% = $1,395.90 | 85% = $1,786.70 |
| | 16:21 HOURS TO 16:30 HOURS (95 basic units) | | |
| 23910 | **Fee:** $1,881.00 | **Benefit:** 75% = $1,410.75 | 85% = $1,806.50 |
| | 16:31 HOURS TO 16:40 HOURS (96 basic units) | | |
| 23920 | **Fee:** $1,900.80 | **Benefit:** 75% = $1,425.60 | 85% = $1,826.30 |
| | 16:41 HOURS TO 16:50 HOURS (97 basic units) | | |
| 23930 | **Fee:** $1,920.60 | **Benefit:** 75% = $1,440.45 | 85% = $1,846.10 |
| | 16:51 HOURS TO 17:00 HOURS (98 basic units) | | |
| 23940 | **Fee:** $1,940.40 | **Benefit:** 75% = $1,455.30 | 85% = $1,865.90 |
| | 17:01 HOURS TO 17:10 HOURS (99 basic units) | | |
| 23950 | **Fee:** $1,960.20 | **Benefit:** 75% = $1,470.15 | 85% = $1,885.70 |
| | 17:11 HOURS TO 17:20 HOURS (100 basic units) | | |
| 23960 | **Fee:** $1,980.00 | **Benefit:** 75% = $1,485.00 | 85% = $1,905.50 |
| | 17:21 HOURS TO 17:30 HOURS (101 basic units) | | |
| 23970 | **Fee:** $1,999.80 | **Benefit:** 75% = $1,499.85 | 85% = $1,925.30 |

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| | 17:31 HOURS TO 17:40 HOURS (102 basic units) | | |
| 23980 | **Fee:** $2,019.60 | **Benefit:** 75% = $1,514.70 | 85% = $1,945.10 |
| | 17:41 HOURS TO 17:50 HOURS (103 basic units) | | |
| 23990 | **Fee:** $2,039.40 | **Benefit:** 75% = $1,529.55 | 85% = $1,964.90 |
| | 17:51 HOURS TO 18:00 HOURS (104 basic units) | | |
| 24100 | **Fee:** $2,059.20 | **Benefit:** 75% = $1,544.40 | 85% = $1,984.70 |
| | 18:01 HOURS TO 18:10 HOURS (105 basic units) | | |
| 24101 | **Fee:** $2,079.00 | **Benefit:** 75% = $1,559.25 | 85% = $2,004.50 |
| | 18:11 HOURS TO 18:20 HOURS (106 basic units) | | |
| 24102 | **Fee:** $2,098.80 | **Benefit:** 75% = $1,574.10 | 85% = $2,024.30 |
| | 18:21 HOURS TO 18:30 HOURS (107 basic units) | | |
| 24103 | **Fee:** $2,118.60 | **Benefit:** 75% = $1,588.95 | 85% = $2,044.10 |
| | 18:31 HOURS TO 18:40 HOURS (108 basic units) | | |
| 24104 | **Fee:** $2,138.40 | **Benefit:** 75% = $1,603.80 | 85% = $2,063.90 |
| | 18:41 HOURS TO 18:50 HOURS (109 basic units) | | |
| 24105 | **Fee:** $2,158.20 | **Benefit:** 75% = $1,618.65 | 85% = $2,083.70 |
| | 18:51 HOURS TO 19:00 HOURS (110 basic units) | | |
| 24106 | **Fee:** $2,178.00 | **Benefit:** 75% = $1,633.50 | 85% = $2,103.50 |
| | 19:01 HOURS TO 19:10 HOURS (111 basic units) | | |
| 24107 | **Fee:** $2,197.80 | **Benefit:** 75% = $1,648.35 | 85% = $2,123.30 |
| | 19:11 HOURS TO 19:20 HOURS (112 basic units) | | |
| 24108 | **Fee:** $2,217.60 | **Benefit:** 75% = $1,663.20 | 85% = $2,143.10 |
| | 19:21 HOURS TO 19:30 HOURS (113 basic units) | | |
| 24109 | **Fee:** $2,237.40 | **Benefit:** 75% = $1,678.05 | 85% = $2,162.90 |
| | 19:31 HOURS TO 19:40 HOURS (114 basic units) | | |
| 24110 | **Fee:** $2,257.20 | **Benefit:** 75% = $1,692.90 | 85% = $2,182.70 |
| | 19:41 HOURS TO 19:50 HOURS (115 basic units) | | |
| 24111 | **Fee:** $2,277.00 | **Benefit:** 75% = $1,707.75 | 85% = $2,202.50 |
| | 19:51 HOURS TO 20:00 HOURS (116 basic units) | | |
| 24112 | **Fee:** $2,296.80 | **Benefit:** 75% = $1,722.60 | 85% = $2,222.30 |
| | 20:01 HOURS TO 20:10 HOURS (117 basic units) | | |
| 24113 | **Fee:** $2,316.60 | **Benefit:** 75% = $1,737.45 | 85% = $2,242.10 |
| | 20:11 HOURS TO 20:20 HOURS (118 basic units) | | |
| 24114 | **Fee:** $2,336.40 | **Benefit:** 75% = $1,752.30 | 85% = $2,261.90 |
| | 20:21 HOURS TO 20:30 HOURS (119 basic units) | | |
| 24115 | **Fee:** $2,356.20 | **Benefit:** 75% = $1,767.15 | 85% = $2,281.70 |
| | 20:31 HOURS TO 20:40 HOURS (120 basic units) | | |
| 24116 | **Fee:** $2,376.00 | **Benefit:** 75% = $1,782.00 | 85% = $2,301.50 |
| | 20:41 HOURS TO 20:50 HOURS (121 basic units) | | |
| 24117 | **Fee:** $2,395.80 | **Benefit:** 75% = $1,796.85 | 85% = $2,321.30 |
| | 20:51 HOURS TO 21:00 HOURS (122 basic units) | | |
| 24118 | **Fee:** $2,415.60 | **Benefit:** 75% = $1,811.70 | 85% = $2,341.10 |
| | 21:01 HOURS TO 21:10 HOURS (123 basic units) | | |
| 24119 | **Fee:** $2,435.40 | **Benefit:** 75% = $1,826.55 | 85% = $2,360.90 |

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| 24120 | 21:11 HOURS TO 21:20 HOURS (124 basic units)<br>**Fee:** $2,455.20 | **Benefit:** 75% = $1,841.40 | 85% = $2,380.70 |
| 24121 | 21:21 HOURS TO 21:30 HOURS (125 basic units)<br>**Fee:** $2,475.00 | **Benefit:** 75% = $1,856.25 | 85% = $2,400.50 |
| 24122 | 21:31 HOURS TO 21:40 HOURS (126 basic units)<br>**Fee:** $2,494.80 | **Benefit:** 75% = $1,871.10 | 85% = $2,420.30 |
| 24123 | 21:41 HOURS TO 21:50 HOURS (127 basic units)<br>**Fee:** $2,514.60 | **Benefit:** 75% = $1,885.95 | 85% = $2,440.10 |
| 24124 | 21:51 HOURS TO 22:00 HOURS (128 basic units)<br>**Fee:** $2,534.40 | **Benefit:** 75% = $1,900.80 | 85% = $2,459.90 |
| 24125 | 22:01 HOURS TO 22:10 HOURS (129 basic units)<br>**Fee:** $2,554.20 | **Benefit:** 75% = $1,915.65 | 85% = $2,479.70 |
| 24126 | 22:11 HOURS TO 22:20 HOURS (130 basic units)<br>**Fee:** $2,574.00 | **Benefit:** 75% = $1,930.50 | 85% = $2,499.50 |
| 24127 | 22:21 HOURS TO 22:30 HOURS (131 basic units)<br>**Fee:** $2,593.80 | **Benefit:** 75% = $1,945.35 | 85% = $2,519.30 |
| 24128 | 22:31 HOURS TO 22:40 HOURS (132 basic units)<br>**Fee:** $2,613.60 | **Benefit:** 75% = $1,960.20 | 85% = $2,539.10 |
| 24129 | 22:41 HOURS TO 22:50 HOURS (133 basic units)<br>**Fee:** $2,633.40 | **Benefit:** 75% = $1,975.05 | 85% = $2,558.90 |
| 24130 | 22:51 HOURS TO 23:00 HOURS (134 basic units)<br>**Fee:** $2,653.20 | **Benefit:** 75% = $1,989.90 | 85% = $2,578.70 |
| 24131 | 23:01 HOURS TO 23:10 HOURS (135 basic units)<br>**Fee:** $2,673.00 | **Benefit:** 75% = $2,004.75 | 85% = $2,598.50 |
| 24132 | 23:11 HOURS TO 23:20 HOURS (136 basic units)<br>**Fee:** $2,692.80 | **Benefit:** 75% = $2,019.60 | 85% = $2,618.30 |
| 24133 | 23:21 HOURS TO 23:30 HOURS (137 basic units)<br>**Fee:** $2,712.60 | **Benefit:** 75% = $2,034.45 | 85% = $2,638.10 |
| 24134 | 23:31 HOURS TO 23:40 HOURS (138 basic units)<br>**Fee:** $2,732.40 | **Benefit:** 75% = $2,049.30 | 85% = $2,657.90 |
| 24135 | 23:41 HOURS TO 23:50 HOURS (139 basic units)<br>**Fee:** $2,752.20 | **Benefit:** 75% = $2,064.15 | 85% = $2,677.70 |
| 24136 | 23:51 HOURS TO 24:00 HOURS (140 basic units)<br>**Fee:** $2,772.00 | **Benefit:** 75% = $2,079.00 | 85% = $2,697.50 |
| | *SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS* | | |
| 25000 | **ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA**<br>(a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or<br>(b) for perfusion performed in association with item 22060; or<br>(c) for assistance at anaesthesia performed in association with items 25200 to 25205<br>Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units)<br>*(See para T10.3 of explanatory notes to this Category)*<br>**Fee:** $19.80 | **Benefit:** 75% = $14.85 | 85% = $16.85 |
| 25005 | Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units)<br>*(See para T10.3 of explanatory notes to this Category)*<br>**Fee:** $39.60 | **Benefit:** 75% = $29.70 | 85% = $33.70 |

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| 25010 | 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)<br>*(See para T10.3 of explanatory notes to this Category)*<br>**Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50 |
| | *SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER* |
| 25015 | **ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA**<br>- where the patient is less than 12 months of age or 70 years or greater (1 basic units)<br>**Fee:** $19.80 **Benefit:** 75% = $14.85 85% = $16.85 |
| 25020 | **ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA**<br>- 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)<br>*(See para T10.3 of explanatory notes to this Category)*<br>**Fee:** $39.60 **Benefit:** 75% = $29.70 85% = $33.70 |
| | *SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER* |
| 25025 | **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<br>*(See para T10.3 of explanatory notes to this Category)*<br>**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 |
| 25030 | **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<br>*(See para T10.3 of explanatory notes to this Category)*<br>**Derived Fee:** An additional amount of 50% of the fee for assistance at anaesthesia. That is:<br>(a) an assistant anaesthesia item in the range 25200 - 25205, plus<br>(b) an item in the range 23010 - 24136, plus<br>(c) where applicable, an item in the range 25000-25015, plus<br>(d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051 |
| | *SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER* |
| 25050 | **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<br>*(See para T10.3 of explanatory notes to this Category)*<br>**Derived Fee:** An additional amount of 50% of the fee for the perfusion service. That is:<br>(a) item 22060, plus<br>(b) an item in the range 23010 - 24136, plus<br>(c) where applicable, an item in the range 25000 - 25015, plus<br>(d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051 or 22065-22075 |
| | *SUBGROUP 26 - ASSISTANCE AT ANAESTHESIA* |
| 25200 | **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)<br>*(See para T10.9 of explanatory notes to this Category)*<br>**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 |

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| 25205 | **ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA** where:<br>(i) the patient has complex airway problems; or<br>(ii) the patient is a neonate or a complex paediatric case; or<br>(iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or<br>(iv) the patient is critically ill, with multiple organ failure; or<br>(v) where the anaesthesia time exceeds 6 hours<br>and the assistance is provided to the exclusion of all other patients (5 basic units)<br>*(See para T10.9 of explanatory notes to this Category)*<br>**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 |

## GROUP T8 - SURGICAL OPERATIONS

### *SUBGROUP 1 - GENERAL*

30001 OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds
*(See para T8.5 of explanatory notes to this Category)*
**Derived Fee:** 50% of the fee which would have applied had the procedure not been discontinued

30003 LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation
**Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90

30006 EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation
**Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55

30009 G LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)
**Fee:** $60.75 **Benefit:** 75% = $45.60
30010 S **Fee:** $73.90 **Benefit:** 75% = $55.45

30013 G EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)
**Fee:** $130.90 **Benefit:** 75% = $98.20
30014 S **Fee:** $155.40 **Benefit:** 75% = $116.55

30017 BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)
**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15

30020 BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)
**Fee:** $635.00 **Benefit:** 75% = $476.25

30023 WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)
*(See para T8.6 of explanatory notes to this Category)*
**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15

30024 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.)
**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15

30026 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.)
*(See para T8.6 of explanatory notes to this Category)*
**Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40

30029 SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)
*(See para T8.6 of explanatory notes to this Category)*
**Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50

30032 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.)
*(See para T8.6 of explanatory notes to this Category)*
**Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15

30035 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), involving deeper tissue (Anaes.)
*(See para T8.6 of explanatory notes to this Category)*
**Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95

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| | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)<br>*(See para T8.6 of explanatory notes to this Category)* | | |
| 30038 | **Fee:** $90.00 | **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, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)<br>*(See para T8.6 of explanatory notes to this Category)* | | |
| 30041 G | **Fee:** $144.00 | **Benefit:** 75% = $108.00 | 85% = $122.40 |
| 30042 S | **Fee:** $185.60 | **Benefit:** 75% = $139.20 | 85% = $157.80 |
| | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.)<br>*(See para T8.6 of explanatory notes to this Category)* | | |
| 30045 | **Fee:** $117.55 | **Benefit:** 75% = $88.20 | 85% = $99.95 |
| | SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)<br>*(See para T8.6 of explanatory notes to this Category)* | | |
| 30048 G | **Fee:** $149.75 | **Benefit:** 75% = $112.35 | 85% = $127.30 |
| 30049 S | **Fee:** $185.60 | **Benefit:** 75% = $139.20 | 85% = $157.80 |
| | FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) | | |
| 30052 | **Fee:** $254.00 | **Benefit:** 75% = $190.50 | 85% = $215.90 |
| | WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in 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.) | | |
| 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.) | | |
| 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 closure of wound if performed, as an independent procedure (Anaes.) | | |
| 30064 | **Fee:** $109.90 | **Benefit:** 75% = $82.45 | 85% = $93.45 |
| | FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) | | |
| 30067 G | **Fee:** $223.60 | **Benefit:** 75% = $167.70 | 85% = $190.10 |
| 30068 S | **Fee:** $276.80 | **Benefit:** 75% = $207.60 | 85% = $235.30 |
| | DIAGNOSTIC BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30071 | **Fee:** $52.20<br>**Extended Medicare Safety Net Cap:** $41.80 | **Benefit:** 75% = $39.15 | 85% = $44.40 |
| | DIAGNOSTIC BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30074 G | **Fee:** $117.55 | **Benefit:** 75% = $88.20 | 85% = $99.95 |
| 30075 S | **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.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30078 | **Fee:** $48.45 | **Benefit:** 75% = $36.35 | 85% = $41.20 |

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| | DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30081 | **Fee:** $109.90 | **Benefit:** 75% = $82.45 | 85% = $93.45 |
| | DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach with a Jamshidi needle or similar device, where the biopsy is sent for pathological examination (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30084 | **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.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30087 | **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.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30090 | **Fee:** $128.55 | **Benefit:** 75% = $96.45 | 85% = $109.30 |
| | DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30093 | **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.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30094 | **Fee:** $189.40 | **Benefit:** 75% = $142.05 | 85% = $161.00 |
| | DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.)<br>*(See para T8.7 of explanatory notes to this Category)* | | |
| 30096 | **Fee:** $183.90 | **Benefit:** 75% = $137.95 | 85% = $156.35 |
| | Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented. | | |
| 30097 | **Fee:** $97.15 | **Benefit:** 75% = $72.90 | 85% = $82.60 |
| | SINUS, excision of, involving superficial tissue only (Anaes.) | | |
| 30099 | **Fee:** $90.00 | **Benefit:** 75% = $67.50 | 85% = $76.50 |
| | SINUS, excision of, involving muscle and deep tissue (Anaes.) | | |
| 30102 G | **Fee:** $149.75 | **Benefit:** 75% = $112.35 | 85% = $127.30 |
| 30103 S | **Fee:** $183.90 | **Benefit:** 75% = $137.95 | 85% = $156.35 |
| | PRE-AURICULAR SINUS, excision of (Anaes.) | | |
| 30104 | **Fee:** $126.90 | **Benefit:** 75% = $95.20 | 85% = $107.90 |
| | GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) | | |
| 30106 G | **Fee:** $155.40 | **Benefit:** 75% = $116.55 | 85% = $132.10 |
| 30107 S | **Fee:** $219.95 | **Benefit:** 75% = $165.00 | 85% = $187.00 |
| | BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.) | | |
| 30110 G | **Fee:** $284.35 | **Benefit:** 75% = $213.30 | 85% = $241.70 |
| 30111 S | **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 transverse wedge excision of abdominal apron, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.)<br>*(See para T8.8 of explanatory notes to this Category)* | | |
| 30165 | **Fee:** $454.85 | **Benefit:** 75% = $341.15 | |

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| 30168 | LIPECTOMY wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 1 EXCISION (Anaes.) (Assist.)<br>*(See para T8.8 of explanatory notes to this Category)*<br>**Fee:** $454.85 **Benefit:** 75% = $341.15 |
| 30171 | LIPECTOMY wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 2 OR MORE EXCISIONS (Anaes.) (Assist.)<br>*(See para T8.8 of explanatory notes to this Category)*<br>**Fee:** $691.75 **Benefit:** 75% = $518.85 |
| 30174 | LIPECTOMY subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall, not being a service associated with items 45564 or 45565 or 45530 (Anaes.) (Assist.)<br>*(See para T8.8 of explanatory notes to this Category)*<br>**Fee:** $691.75 **Benefit:** 75% = $518.85 |
| 30177 | LIPECTOMY radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.)<br>*(See para T8.8 of explanatory notes to this Category)*<br>**Fee:** $985.70 **Benefit:** 75% = $739.30 |
| 30180 | AXILLARY HYPERHIDROSIS, partial excision for (Anaes.)<br>**Fee:** $136.50 **Benefit:** 75% = $102.40 85% = $116.05 |
| 30183 | AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.)<br>**Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55 |
| 30185 | PALMAR OR PLANTAR WARTS (10 or more), definitive removal of, excluding ablative methods alone, not being a service to which item 30186 or 30187 applies (Anaes.)<br>*(See para T8.9 of explanatory notes to this Category)*<br>**Fee:** $182.50 **Benefit:** 75% = $136.90 85% = $155.15 |
| 30186 | PALMAR OR PLANTAR WARTS (less than 10), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies (Anaes.)<br>*(See para T8.9 of explanatory notes to this Category)*<br>**Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35 |
| 30187 | 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.)<br>*(See para T8.9 of explanatory notes to this Category)*<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45 |
| 30189 | WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>*(See para T8.9 of explanatory notes to this Category)*<br>**Fee:** $147.30 **Benefit:** 75% = $110.50 |
| 30190 | ANGIOFIBROMAS, TRICHOEPITHELIOMAS or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser or erbium laser excision-ablation including associated resurfacing (10 or more tumours) (Anaes.) (Assist.)<br>**Fee:** $397.75 **Benefit:** 75% = $298.35 85% = $338.10 |
| 30192 | PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)<br>*(See para T8.9 of explanatory notes to this Category)*<br>**Fee:** $39.55 **Benefit:** 75% = $29.70 85% = $33.65 |
| 30195 | BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions) (Anaes.)<br>*(See para T8.9 of explanatory notes to this Category)*<br>**Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00 |

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| 30196 | MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.)<br>*(See para T8.10 of explanatory notes to this Category)*<br>**Fee:** $126.30 | **Benefit:** 75% = $94.75 | 85% = $107.40 |
| 30197 | MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 OR MORE LESIONS) (Anaes.)<br>*(See para T8.10 of explanatory notes to this Category)*<br>**Fee:** $440.05 | **Benefit:** 75% = $330.05 | 85% = $374.05 |
| 30202 | MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies<br>*(See para T8.10 of explanatory notes to this Category)*<br>**Fee:** $48.35 | **Benefit:** 75% = $36.30 | 85% = $41.10 |
| 30203 | MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS)<br>*(See para T8.10 of explanatory notes to this Category)*<br>**Fee:** $170.25 | **Benefit:** 75% = $127.70 | 85% = $144.75 |
| 30205 | MALIGNANT NEOPLASM OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE THE MALIGNANT NEOPLASM EXTENDS INTO CARTILAGE (Anaes.)<br>**Fee:** $126.30 | **Benefit:** 75% = $94.75 | 85% = $107.40 |
| 30207 | SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes.)<br>**Fee:** $44.60 | **Benefit:** 75% = $33.45 | 85% = $37.95 |
| 30210 | KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $162.95 | **Benefit:** 75% = $122.25 | |
| 30213 | TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.)<br>*(See para T8.11 of explanatory notes to this Category)*<br>**Fee:** $109.80 | **Benefit:** 75% = $82.35 | 85% = $93.35 |
| 30214 | TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - session of at least 20 minutes duration ***- where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period***<br>*(See para T8.11 of explanatory notes to this Category)*<br>**Fee:** $109.80 | **Benefit:** 75% = $82.35 | 85% = $93.35 |
| 30216 | HAEMATOMA, aspiration of (Anaes.)<br>**Fee:** $27.35 | **Benefit:** 75% = $20.55 | 85% = $23.25 |
| 30219 | HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)<br>**Fee:** $27.35 | **Benefit:** 75% = $20.55 | 85% = $23.25 |
| 30223 | LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.)<br>**Fee:** $162.95 | **Benefit:** 75% = $122.25 | |
| 30224 | PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.)<br>**Fee:** $237.60 | **Benefit:** 75% = $178.20 | 85% = $202.00 |
| 30225 | ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.)<br>**Fee:** $267.65 | **Benefit:** 75% = $200.75 | 85% = $227.55 |
| 30226 | MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.)<br>**Fee:** $149.75 | **Benefit:** 75% = $112.35 | 85% = $127.30 |

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| 30229 | MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05 |
| 30232 | MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.)<br>**Fee:** $223.60 **Benefit:** 75% = $167.70 85% = $190.10 |
| 30235 | MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35 |
| 30238 | FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.)<br>**Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30 |
| 30241 | BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90 |
| 30244 | STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 30246 | PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.)<br>**Fee:** $689.80 **Benefit:** 75% = $517.35 |
| 30247 | PAROTID GLAND, total extirpation of (Anaes.) (Assist.)<br>**Fee:** $739.35 **Benefit:** 75% = $554.55 |
| 30250 | PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)<br>**Fee:** $1,251.10 **Benefit:** 75% = $938.35 |
| 30251 | RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.)<br>**Fee:** $1,921.75 **Benefit:** 75% = $1,441.35 85% = $1,847.25 |
| 30253 | PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.)<br>**Fee:** $834.05 **Benefit:** 75% = $625.55 |
| 30255 | SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)<br>**Fee:** $1,110.65 **Benefit:** 75% = $833.00 |
| 30256 | SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.)<br>**Fee:** $445.40 **Benefit:** 75% = $334.05 |
| 30259 | SUBLINGUAL GLAND, extirpation of (Anaes.)<br>**Fee:** $198.50 **Benefit:** 75% = $148.90 85% = $168.75 |
| 30262 | SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.)<br>**Fee:** $58.80 **Benefit:** 75% = $44.10 85% = $50.00 |
| 30265 G<br>30266 S | SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.)<br>**Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95<br>**Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30 |
| 30269 | SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.)<br>**Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30 |
| 30272 | TONGUE, partial excision of (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35 |
| 30275 | RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.)<br>**Fee:** $1,762.75 **Benefit:** 75% = $1,322.10 |
| 30278 | TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.)<br>**Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55 |
| 30281 | TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.)<br>**Fee:** $119.50 **Benefit:** 75% = $89.65 85% = $101.60 |

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| | RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) |
| 30282 G | **Fee:** $155.40 **Benefit:** 75% = $116.55 85% = $132.10 |
| 30283 S | **Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00 |
| | BRANCHIAL CYST, removal of (Anaes.) (Assist.) |
| 30286 | **Fee:** $397.85 **Benefit:** 75% = $298.40 85% = $338.20 |
| | BRANCHIAL FISTULA, 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 |
| | CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) |
| 30294 | **Fee:** $1,762.75 **Benefit:** 75% = $1,322.10 |
| | THYROIDECTOMY, total (Anaes.) (Assist.) |
| 30296 | **Fee:** $1,023.70 **Benefit:** 75% = $767.80 |
| | THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) |
| 30297 | **Fee:** $1,023.70 **Benefit:** 75% = $767.80 |
| | SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* |
| 30299 | **Fee:** $637.45 **Benefit:** 75% = $478.10 |
| | SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* |
| 30300 | **Fee:** $764.90 **Benefit:** 75% = $573.70 |
| | SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* |
| 30302 | **Fee:** $509.95 **Benefit:** 75% = $382.50 |
| | SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* |
| 30303 | **Fee:** $611.85 **Benefit:** 75% = $458.90 |
| | TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) |
| 30306 | **Fee:** $798.65 **Benefit:** 75% = $599.00 |
| | BILATERAL SUBTOTAL THYROIDECTOMY (Anaes.) (Assist.) |
| 30308 | **Fee:** $798.65 **Benefit:** 75% = $599.00 |
| | THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assist.) |
| 30309 | **Fee:** $1,023.70 **Benefit:** 75% = $767.80 |
| | THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.) (Assist.) |
| 30310 | **Fee:** $457.40 **Benefit:** 75% = $343.05 |
| | THYROGLOSSAL CYST, removal of (Anaes.) (Assist.) |
| 30313 | **Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05 |
| | THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) |
| 30314 | **Fee:** $457.40 **Benefit:** 75% = $343.05 |

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| 30315 | PARATHYROID operation for hyperparathyroidism (Anaes.) (Assist.)<br>**Fee:** $1,139.90 **Benefit:** 75% = $854.95 |
| 30317 | CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes.) (Assist.)<br>**Fee:** $1,364.90 **Benefit:** 75% = $1,023.70 |
| 30318 | MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.)<br>**Fee:** $907.60 **Benefit:** 75% = $680.70 |
| 30320 | MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.)<br>**Fee:** $1,364.90 **Benefit:** 75% = $1,023.70 |
| 30321 | RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes.) (Assist.)<br>**Fee:** $907.60 **Benefit:** 75% = $680.70 |
| 30323 | RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes.) (Assist.)<br>**Fee:** $1,364.90 **Benefit:** 75% = $1,023.70 |
| 30324 | ADRENAL GLAND TUMOUR, excision of (Anaes.) (Assist.)<br>**Fee:** $1,364.90 **Benefit:** 75% = $1,023.70 |
| 30329 | LYMPH GLANDS of GROIN, limited excision of (Anaes.)<br>**Fee:** $246.95 **Benefit:** 75% = $185.25 85% = $209.95 |
| 30330 | LYMPH GLANDS of GROIN, radical excision of (Anaes.) (Assist.)<br>**Fee:** $718.75 **Benefit:** 75% = $539.10 |
| 30332 | LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)<br>**Fee:** $346.75 **Benefit:** 75% = $260.10 |
| 30335 | LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.)<br>*(See para T8.13 of explanatory notes to this Category)*<br>**Fee:** $866.85 **Benefit:** 75% = $650.15 |
| 30336 | LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.)<br>*(See para T8.13 of explanatory notes to this Category)*<br>**Fee:** $1,040.25 **Benefit:** 75% = $780.20 |
| 30373 | LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.)<br>**Fee:** $483.25 **Benefit:** 75% = $362.45 |
| 30375 | Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, 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.)<br>*(See para T8.14 of explanatory notes to this Category)*<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 30376 | LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 30378 | 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 (Anaes.) (Assist.)<br>**Fee:** $523.70 **Benefit:** 75% = $392.80 |
| 30379 | LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.)<br>**Fee:** $928.15 **Benefit:** 75% = $696.15 |
| 30382 | ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.)<br>**Fee:** $1,306.90 **Benefit:** 75% = $980.20 |
| 30384 | LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.)<br>**Fee:** $1,099.40 **Benefit:** 75% = $824.55 |

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| 30385 | LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.)<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 |
| 30387 | LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $635.00 **Benefit:** 75% = $476.25 |
| 30388 | LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.)<br>**Fee:** $1,597.55 **Benefit:** 75% = $1,198.20 |
| 30390 | LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure (Anaes.)<br>*(See para T8.15 of explanatory notes to this Category)*<br>**Fee:** $219.95 **Benefit:** 75% = $165.00 |
| 30391 | LAPAROSCOPY with biopsy (Anaes.) (Assist.)<br>**Fee:** $284.35 **Benefit:** 75% = $213.30 |
| 30392 | RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $674.50 **Benefit:** 75% = $505.90 |
| 30393 | LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)<br>**Fee:** $523.70 **Benefit:** 75% = $392.80 |
| 30394 | LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.)<br>**Fee:** $492.85 **Benefit:** 75% = $369.65 |
| 30396 | 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.)<br>*(See para T8.16 of explanatory notes to this Category)*<br>**Fee:** $1,016.55 **Benefit:** 75% = $762.45 |
| 30397 | LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.)<br>**Fee:** $232.35 **Benefit:** 75% = $174.30 |
| 30399 | LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes.) (Assist.)<br>**Fee:** $319.60 **Benefit:** 75% = $239.70 |
| 30400 | LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.)<br>**Fee:** $632.50 **Benefit:** 75% = $474.40 |
| 30402 | RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.)<br>**Fee:** $464.60 **Benefit:** 75% = $348.45 |
| 30403 | VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 30405 | VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.)<br>**Fee:** $914.95 **Benefit:** 75% = $686.25 |
| 30406 | PARACENTESIS ABDOMINIS (Anaes.)<br>**Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40 |
| 30408 | PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.)<br>**Fee:** $392.10 **Benefit:** 75% = $294.10 |
| 30409 | LIVER BIOPSY, percutaneous (Anaes.)<br>**Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30 |

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| 30411 | LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.)<br>**Fee:** $88.80 **Benefit:** 75% = $66.60 |
| 30412 | LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.)<br>**Fee:** $52.35 **Benefit:** 75% = $39.30 85% = $44.50 |
| 30414 | LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.)<br>**Fee:** $689.80 **Benefit:** 75% = $517.35 |
| 30415 | LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.)<br>**Fee:** $1,379.50 **Benefit:** 75% = $1,034.65 |
| 30416 | LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.)<br>**Fee:** $748.95 **Benefit:** 75% = $561.75 |
| 30417 | LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.)<br>**Fee:** $1,123.40 **Benefit:** 75% = $842.55 |
| 30418 | LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.)<br>**Fee:** $1,597.55 **Benefit:** 75% = $1,198.20 |
| 30419 | LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.)<br>**Fee:** $817.10 **Benefit:** 75% = $612.85 85% = $742.60 |
| 30421 | LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.)<br>**Fee:** $1,996.55 **Benefit:** 75% = $1,497.45 |
| 30422 | LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.)<br>**Fee:** $675.35 **Benefit:** 75% = $506.55 |
| 30425 | LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)<br>**Fee:** $1,306.90 **Benefit:** 75% = $980.20 |
| 30427 | LIVER, segmental resection of, for trauma (Anaes.) (Assist.)<br>**Fee:** $1,560.95 **Benefit:** 75% = $1,170.75 |
| 30428 | LIVER, lobectomy of, for trauma (Anaes.) (Assist.)<br>**Fee:** $1,670.00 **Benefit:** 75% = $1,252.50 85% = $1,595.50 |
| 30430 | LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)<br>**Fee:** $2,323.30 **Benefit:** 75% = $1,742.50 85% = $2,248.80 |
| 30431 | LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 85% = $446.75 |
| 30433 | LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.)<br>**Fee:** $726.05 **Benefit:** 75% = $544.55 |
| 30434 | HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.)<br>**Fee:** $588.15 **Benefit:** 75% = $441.15 |
| 30436 | HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.)<br>**Fee:** $653.45 **Benefit:** 75% = $490.10 |
| 30437 | HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.)<br>**Fee:** $813.30 **Benefit:** 75% = $610.00 |
| 30438 | HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)<br>**Fee:** $1,150.85 **Benefit:** 75% = $863.15 85% = $1,076.35 |
| 30439 | OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.)<br>**Fee:** $185.60 **Benefit:** 75% = $139.20 |

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| 30440 | CHOLANGIOGRAM, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Anaes.) (Assist.)<br>**Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $451.90 |
| 30441 | INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.)<br>**Fee:** $136.25 **Benefit:** 75% = $102.20 |
| 30442 | CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.)<br>**Fee:** $185.60 **Benefit:** 75% = $139.20 |
| 30443 | CHOLECYSTECTOMY (Anaes.) (Assist.)<br>**Fee:** $739.35 **Benefit:** 75% = $554.55 |
| 30445 | LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.)<br>**Fee:** $739.35 **Benefit:** 75% = $554.55 |
| 30446 | LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.)<br>**Fee:** $739.35 **Benefit:** 75% = $554.55 |
| 30448 | LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.)<br>**Fee:** $972.90 **Benefit:** 75% = $729.70 |
| 30449 | LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.)<br>**Fee:** $1,081.85 **Benefit:** 75% = $811.40 |
| 30450 | CALCULUS OF BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Anaes.) (Assist.)<br>**Fee:** $524.40 **Benefit:** 75% = $393.30 85% = $449.90 |
| 30451 | BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.)<br>**Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55 |
| 30452 | CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.)<br>**Fee:** $377.50 **Benefit:** 75% = $283.15 |
| 30454 | CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.)<br>**Fee:** $862.50 **Benefit:** 75% = $646.90 |
| 30455 | CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,014.05 **Benefit:** 75% = $760.55 |
| 30457 | CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.)<br>**Fee:** $1,379.50 **Benefit:** 75% = $1,034.65 85% = $1,305.00 |
| 30458 | 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.)<br>**Fee:** $1,014.05 **Benefit:** 75% = $760.55 |
| 30460 | CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.)<br>**Fee:** $862.50 **Benefit:** 75% = $646.90 |
| 30461 | RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.)<br>**Fee:** $1,478.40 **Benefit:** 75% = $1,108.80 |
| 30463 | RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.)<br>**Fee:** $1,815.20 **Benefit:** 75% = $1,361.40 |
| 30464 | RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.)<br>**Fee:** $2,178.25 **Benefit:** 75% = $1,633.70 |

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| 30466 | INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.)<br>**Fee:** $1,256.05 **Benefit:** 75% = $942.05 |
| 30467 | INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.)<br>**Fee:** $1,553.70 **Benefit:** 75% = $1,165.30 |
| 30469 | BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.)<br>**Fee:** $1,720.90 **Benefit:** 75% = $1,290.70 85% = $1,646.40 |
| 30472 | HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.)<br>**Fee:** $929.35 **Benefit:** 75% = $697.05 85% = $854.85 |
| 30473 | OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $177.10 **Benefit:** 75% = $132.85 85% = $150.55 |
| 30475 | ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $320.25 **Benefit:** 75% = $240.20 85% = $272.25 |
| 30476 | OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $245.55 **Benefit:** 75% = $184.20 85% = $208.75 |
| 30478 | OESOPHAGOSCOPY (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $245.55 **Benefit:** 75% = $184.20 85% = $208.75 |
| 30479 | ENDOSCOPY with LASER THERAPY or ARGON PLASMA COAGULATION, for the treatment of neoplasia, benign vascular lesions, strictures of the gastrointestinal tract, tumorous overgrowth through or over oesophageal stents, peptic ulcers, angiodysplasia, gastric antral vascular ectasia (GAVE) or post-polypectomy bleeding, 1 or more of (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $476.10 **Benefit:** 75% = $357.10 85% = $404.70 |
| 30481 | PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45 |
| 30482 | PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes.)<br>**Fee:** $253.85 **Benefit:** 75% = $190.40 85% = $215.80 |
| 30483 | GASTROSTOMY BUTTON, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.)<br>**Fee:** $177.05 **Benefit:** 75% = $132.80 85% = $150.50 |
| 30484 | ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $364.90 **Benefit:** 75% = $273.70 85% = $310.20 |
| 30485 | ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $488.80 |
| 30487 | SMALL BOWEL INTUBATION with biopsy, as an independent procedure (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80 |
| 30488 | SMALL BOWEL INTUBATION as an independent procedure (Anaes.)<br>**Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50 |

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| 30490 | OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $451.90 |
| 30491 | BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $555.35 **Benefit:** 75% = $416.55 85% = $480.85 |
| 30492 | BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.)<br>**Fee:** $787.30 **Benefit:** 75% = $590.50 |
| 30493 | BILIARY MANOMETRY (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $333.20 **Benefit:** 75% = $249.90 85% = $283.25 |
| 30494 | ENDOSCOPIC BILIARY DILATATION (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $420.50 **Benefit:** 75% = $315.40 |
| 30495 | PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.)<br>**Fee:** $787.30 **Benefit:** 75% = $590.50 |
| 30496 | VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.)<br>**Fee:** $588.15 **Benefit:** 75% = $441.15 85% = $513.65 |
| 30497 | VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.)<br>**Fee:** $701.30 **Benefit:** 75% = $526.00 |
| 30499 | VAGOTOMY, highly selective (Anaes.) (Assist.)<br>**Fee:** $834.05 **Benefit:** 75% = $625.55 |
| 30500 | VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.)<br>**Fee:** $893.10 **Benefit:** 75% = $669.85 85% = $818.60 |
| 30502 | VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.)<br>**Fee:** $985.70 **Benefit:** 75% = $739.30 |
| 30503 | VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.)<br>**Fee:** $1,103.80 **Benefit:** 75% = $827.85 85% = $1,029.30 |
| 30505 | BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.)<br>**Fee:** $551.85 **Benefit:** 75% = $413.90 |
| 30506 | BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.)<br>**Fee:** $965.75 **Benefit:** 75% = $724.35 |
| 30508 | BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.)<br>**Fee:** $1,016.55 **Benefit:** 75% = $762.45 |
| 30509 | BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.)<br>**Fee:** $1,016.55 **Benefit:** 75% = $762.45 85% = $942.05 |
| 30511 | (*see Item 31441 for repair, revision or replacement of implanted reservoir associated with adjustable gastric band*)<br>(*see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band*)<br><br>MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes.) (Assist.)<br>**Fee:** $849.55 **Benefit:** 75% = $637.20 |
| 30512 | MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,045.40 **Benefit:** 75% = $784.05 |

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| 30514 | MORBID OBESITY, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.)<br>*(See para T8.18 of explanatory notes to this Category)*<br>**Fee:** $1,539.10 **Benefit:** 75% = $1,154.35 |
| 30515 | GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (Anaes.) (Assist.)<br>**Fee:** $704.35 **Benefit:** 75% = $528.30 |
| 30517 | GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.)<br>**Fee:** $922.20 **Benefit:** 75% = $691.65 |
| 30518 | PARTIAL GASTRECTOMY (Anaes.) (Assist.)<br>**Fee:** $987.50 **Benefit:** 75% = $740.65 |
| 30520 | GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.)<br>**Fee:** $675.35 **Benefit:** 75% = $506.55 |
| 30521 | GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.)<br>**Fee:** $1,444.90 **Benefit:** 75% = $1,083.70 |
| 30523 | GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.)<br>*(See para T8.19 of explanatory notes to this Category)*<br>**Fee:** $1,510.10 **Benefit:** 75% = $1,132.60 |
| 30524 | GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.)<br>**Fee:** $1,662.65 **Benefit:** 75% = $1,247.00 |
| 30526 | GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.)<br>**Fee:** $2,156.35 **Benefit:** 75% = $1,617.30 |
| 30527 | ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.)<br>*(See para T8.20 of explanatory notes to this Category)*<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 |
| 30529 | ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.)<br>*(See para T8.20 of explanatory notes to this Category)*<br>**Fee:** $1,306.90 **Benefit:** 75% = $980.20 |
| 30530 | ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.)<br>*(See para T8.20 of explanatory notes to this Category)*<br>**Fee:** $784.20 **Benefit:** 75% = $588.15 |
| 30532 | OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.)<br>*(See para T8.20 of explanatory notes to this Category)*<br>**Fee:** $900.45 **Benefit:** 75% = $675.35 |
| 30533 | OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.)<br>*(See para T8.20 of explanatory notes to this Category)*<br>**Fee:** $1,071.00 **Benefit:** 75% = $803.25 |
| 30535 | OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.)<br>**Fee:** $1,696.65 **Benefit:** 75% = $1,272.50 |
| 30536 | OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $1,720.90 **Benefit:** 75% = $1,290.70 |
| 30538 | OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,190.80 **Benefit:** 75% = $893.10 |

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| 30539 | OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.)<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 |
| 30541 | OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $1,517.50 **Benefit:** 75% = $1,138.15 |
| 30542 | OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,031.10 **Benefit:** 75% = $773.35 |
| 30544 | OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.)<br>**Fee:** $755.20 **Benefit:** 75% = $566.40 |
| 30545 | OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $1,837.10 **Benefit:** 75% = $1,377.85 |
| 30547 | OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,263.35 **Benefit:** 75% = $947.55 85% = $1,188.85 |
| 30548 | OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.)<br>**Fee:** $943.80 **Benefit:** 75% = $707.85 85% = $869.30 |
| 30550 | OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $2,062.20 **Benefit:** 75% = $1,546.65 |
| 30551 | OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,423.15 **Benefit:** 75% = $1,067.40 |
| 30553 | OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.)<br>**Fee:** $1,052.65 **Benefit:** 75% = $789.50 85% = $978.15 |
| 30554 | OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $2,294.45 **Benefit:** 75% = $1,720.85 |
| 30556 | OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,582.80 **Benefit:** 75% = $1,187.10 |
| 30557 | OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.)<br>**Fee:** $1,169.00 **Benefit:** 75% = $876.75 |
| 30559 | OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.)<br>**Fee:** $849.55 **Benefit:** 75% = $637.20 85% = $775.05 |
| 30560 | OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)<br>**Fee:** $943.80 **Benefit:** 75% = $707.85 |
| 30562 | ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel (Anaes.) (Assist.)<br>**Fee:** $595.00 **Benefit:** 75% = $446.25 |
| 30563 | COLOSTOMY OR ILEOSTOMY, refashioning of (Anaes.) (Assist.)<br>**Fee:** $595.00 **Benefit:** 75% = $446.25 85% = $520.50 |
| 30564 | SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.)<br>**Fee:** $772.30 **Benefit:** 75% = $579.25 |
| 30565 | SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.)<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 |

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| 30566 | SMALL INTESTINE, resection of, with anastomosis (Anaes.) (Assist.)<br>**Fee:** $967.85 **Benefit:** 75% = $725.90 |
| 30568 | INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.)<br>**Fee:** $726.05 **Benefit:** 75% = $544.55 |
| 30569 | ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.)<br>**Fee:** $370.20 **Benefit:** 75% = $277.65 |
| 30571 | APPENDICECTOMY, not being a service to which item 30574 applies (Anaes.) (Assist.)<br>**Fee:** $445.40 **Benefit:** 75% = $334.05 |
| 30572 | LAPAROSCOPIC APPENDICECTOMY (Anaes.) (Assist.)<br>**Fee:** $445.40 **Benefit:** 75% = $334.05 |
| 30574 | **NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item*<br>APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.)<br>**Fee:** $123.25 **Benefit:** 75% = $92.45 |
| 30575 | PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.)<br>**Fee:** $512.70 **Benefit:** 75% = $384.55 |
| 30577 | PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $1,089.15 **Benefit:** 75% = $816.90 |
| 30578 | ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.)<br>**Fee:** $1,147.20 **Benefit:** 75% = $860.40 |
| 30580 | ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.)<br>**Fee:** $1,045.40 **Benefit:** 75% = $784.05 |
| 30581 | ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.)<br>**Fee:** $762.35 **Benefit:** 75% = $571.80 |
| 30583 | DISTAL PANCREATECTOMY (Anaes.) (Assist.)<br>**Fee:** $1,194.25 **Benefit:** 75% = $895.70 |
| 30584 | PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.)<br>**Fee:** $1,762.75 **Benefit:** 75% = $1,322.10 |
| 30586 | PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.)<br>**Fee:** $701.30 **Benefit:** 75% = $526.00 |
| 30587 | PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)<br>**Fee:** $726.05 **Benefit:** 75% = $544.55 |
| 30589 | PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)<br>**Fee:** $1,251.10 **Benefit:** 75% = $938.35 |
| 30590 | PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)<br>**Fee:** $1,379.50 **Benefit:** 75% = $1,034.65 |
| 30593 | PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.)<br>**Fee:** $1,887.75 **Benefit:** 75% = $1,415.85 85% = $1,813.25 |
| 30594 | PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.)<br>**Fee:** $2,178.25 **Benefit:** 75% = $1,633.70 |
| 30596 | SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)<br>**Fee:** $897.30 **Benefit:** 75% = $673.00 |
| 30597 | SPLENECTOMY (Anaes.) (Assist.)<br>**Fee:** $720.20 **Benefit:** 75% = $540.15 |

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| 30599 | SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.)<br>**Fee:** $1,306.90 **Benefit:** 75% = $980.20 |
| 30600 | DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)<br>**Fee:** $777.10 **Benefit:** 75% = $582.85 |
| 30601 | DIAPHRAGMATIC HERNIA, CONGENITAL repair of, by thoracic or abdominal approach (Anaes.) (Assist.)<br>**Fee:** $957.30 **Benefit:** 75% = $718.00 |
| 30602 | PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.)<br>**Fee:** $1,553.70 **Benefit:** 75% = $1,165.30 |
| 30603 | PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.)<br>**Fee:** $1,640.90 **Benefit:** 75% = $1,230.70 85% = $1,566.40 |
| 30605 | PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.)<br>**Fee:** $1,865.95 **Benefit:** 75% = $1,399.50 |
| 30606 | PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.)<br>**Fee:** $1,110.80 **Benefit:** 75% = $833.10 |
| 30609 | FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Anaes.) (Assist.)<br>**Fee:** $464.50 **Benefit:** 75% = $348.40 |
| 30612 G<br>30614 S | FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30<br>**Fee:** $464.50 **Benefit:** 75% = $348.40 |
| 30615 | STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 30616 G<br>30617 S | UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (Anaes.)<br>**Fee:** $265.30 **Benefit:** 75% = $199.00<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 30620 G<br>30621 S | UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (Anaes.) (Assist.)<br>**Fee:** $299.45 **Benefit:** 75% = $224.60<br>**Fee:** $407.50 **Benefit:** 75% = $305.65 |
| 30628 | HYDROCELE, tapping of<br>**Fee:** $35.60 **Benefit:** 75% = $26.70 85% = $30.30 |
| 30631 | HYDROCELE, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.)<br>**Fee:** $236.65 **Benefit:** 75% = $177.50 85% = $201.20 |
| 30634 G<br>30635 S | VARICOCELE, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Anaes.) (Assist.)<br>**Fee:** $235.05 **Benefit:** 75% = $176.30<br>**Fee:** $291.80 **Benefit:** 75% = $218.85 |
| 30638 G<br>30641 S | ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.)<br>**Fee:** $299.45 **Benefit:** 75% = $224.60<br>**Fee:** $407.50 **Benefit:** 75% = $305.65 |
| 30644 | EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 30653 | CIRCUMCISION of a male UNDER 6 MONTHS of age (Anaes.)<br>**Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55 |
| 30656 | CIRCUMCISION of a male UNDER 10 YEARS of age but not less than 6 months of age (Anaes.)<br>**Fee:** $108.15 **Benefit:** 75% = $81.15 85% = $91.95 |

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| | CIRCUMCISION of a male 10 YEARS OF AGE OR OVER (Anaes.) |
| 30659 G | **Fee:** $149.75 **Benefit:** 75% = $112.35 85% = $127.30 |
| 30660 S | **Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80 |
| | HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (Anaes.) |
| 30663 | **Fee:** $144.35 **Benefit:** 75% = $108.30 85% = $122.70 |
| | PARAPHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.) |
| 30666 | **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35 |
| | COCCYX, excision of (Anaes.) (Assist.) |
| 30672 | **Fee:** $445.40 **Benefit:** 75% = $334.05 |
| | PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.) |
| 30675 G | **Fee:** $299.45 **Benefit:** 75% = $224.60 85% = $254.55 |
| 30676 S | **Fee:** $379.05 **Benefit:** 75% = $284.30 85% = $322.20 |
| | PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) |
| 30679 | **Fee:** $96.30 **Benefit:** 75% = $72.25 85% = $81.90 |
| | DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686)<br><br>The patient to whom the service is provided must:<br>(i) have recurrent or persistent bleeding; and<br>(ii) be anaemic or have active bleeding; and<br>(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding.<br>(Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)* |
| 30680 | **Fee:** $1,170.00 **Benefit:** 75% = $877.50 85% = $1,095.50 |
| | DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684)<br><br>The patient to whom the service is provided must:<br>- have recurrent or persistent bleeding; and<br>- be anaemic or have active bleeding; and<br>(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding.<br>(Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)* |
| 30682 | **Fee:** $1,170.00 **Benefit:** 75% = $877.50 85% = $1,095.50 |
| | DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686)<br><br>The patient to whom the service is provided must:<br>- have recurrent or persistent bleeding; and<br>- be anaemic or have active bleeding; and<br>- have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)* |
| 30684 | **Fee:** $1,439.85 **Benefit:** 75% = $1,079.90 85% = $1,365.35 |

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| 30686 | DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684)<br><br>The patient to whom the service is provided must:<br>- have recurrent or persistent bleeding; and<br>- be anaemic or have active bleeding; and<br>(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $1,439.85 **Benefit:** 75% = $1,079.90 85% = $1,365.35 |
| 30687 | ENDOSCOPY with RADIOFREQUENCY ABLATION of mucosal metaplasia for the treatment of Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.)<br>*(See para T8.17 and T8.21 of explanatory notes to this Category)*<br>**Fee:** $476.10 **Benefit:** 75% = $357.10 85% = $404.70 |
| 30688 | ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)<br>*(See para T8.17 and T8.22 of explanatory notes to this Category)*<br>**Fee:** $364.90 **Benefit:** 75% = $273.70 85% = $310.20 |
| 30690 | ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)<br>*(See para T8.17 and T8.22 of explanatory notes to this Category)*<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $488.80 |
| 30692 | ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)<br>*(See para T8.17 and T8.22 of explanatory notes to this Category)*<br>**Fee:** $364.90 **Benefit:** 75% = $273.70 85% = $310.20 |
| 30694 | ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)<br>*(See para T8.17 and T8.22 of explanatory notes to this Category)*<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $488.80 |
| 30696 | ENDOSCOPIC ULTRASOUND GUIDED FINE NEEDLE ASPIRATION BIOPSY(S) (endoscopy with ultrasound imaging) to obtain one or more specimens from either:<br><br>(a) mediastinal mass(es) or<br>(b) locoregional nodes to stage non-small cell lung carcinoma<br><br>not being a service associated with another item in this subgroup or to which items 30710 and 55054 apply (Anaes.)<br>*(See para T8.22 of explanatory notes to this Category)*<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $488.80 |
| 30710 | ENDOBRONCHIAL ULTRASOUND GUIDED BIOPSY(S) (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by either:<br><br>(a) transbronchial biopsy(s) of peripheral lung lesions; or<br>(b) fine needle aspiration(s) of a mediastinal mass(es); or<br>(c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcinoma<br><br>not being a service associated with another item in this subgroup or to which items 30696, 41892, 41898, and 60500 to 60509 applies (Anaes.)<br>*(See para T8.22 of explanatory notes to this Category)*<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 85% = $488.80 |

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| 31000 | MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes.)<br>**Fee:** $580.90 **Benefit:** 75% = $435.70 85% = $506.40 |
| 31001 | MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes.)<br>**Fee:** $726.05 **Benefit:** 75% = $544.55 85% = $651.55 |
| 31002 | MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes.)<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 85% = $796.80 |
| 31200 | TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service associated with a service to which item 45200, 45203 or 45206 applies and not being a service to which another item in this Group applies<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $34.00 **Benefit:** 75% = $25.50 85% = $28.90<br>**Extended Medicare Safety Net Cap:** $27.20 |
| 31205 | TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter**, **removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $95.45 **Benefit:** 75% = $71.60 85% = $81.15<br>**Extended Medicare Safety Net Cap:** $76.40 |
| 31210 | TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 10mm and up to and including 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $123.10 **Benefit:** 75% = $92.35 85% = $104.65 |
| 31215 | TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $143.55 **Benefit:** 75% = $107.70 85% = $122.05 |
| 31220 | 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), **lesion size up to and including 10mm in diameter, removal of 4 to 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $214.55 **Benefit:** 75% = $160.95 85% = $182.40 |
| 31225 | 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), **lesion size up to and including 10mm in diameter, removal of more than 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $381.30 **Benefit:** 75% = $286.00 85% = $324.15 |

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| | TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from nose, eyelid, lip, ear, digit or genitalia,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31230 | **Fee:** $168.05 **Benefit:** 75% = $126.05 85% = $142.85 |
| | TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to and including 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)* |
| 31235 | **Fee:** $143.55 **Benefit:** 75% = $107.70 85% = $122.05 |
| | TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)* |
| 31240 | **Fee:** $168.05 **Benefit:** 75% = $126.05 85% = $142.85 |
| | 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.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)* |
| 31245 | **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.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31250 | **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65 |
| | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter -** where removal is by therapeutic **surgical excision (other than by shave excision) and suture and** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31255 | **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15 |
| | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31256 | **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15 |
| | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31257 | **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15 |
| | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31258 | **Fee:** $221.35 **Benefit:** 75% = $166.05 85% = $188.15 |

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| 31260 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **therapeutic surgical excision (other than shave excision) and suture** ***and where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35 |
| 31261 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35 |
| 31262 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35 |
| 31263 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $315.65 **Benefit:** 75% = $236.75 85% = $268.35 |
| 31265 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85 |
| 31266 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85 |
| 31267 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85 |
| 31268 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $184.50 **Benefit:** 75% = $138.40 85% = $156.85 |

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| 31270 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55 |
| 31271 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55 |
| 31272 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55 |
| 31273 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $258.25 **Benefit:** 75% = $193.70 85% = $219.55 |
| 31275 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40 |
| 31276 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40 |
| 31277 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40 |
| 31278 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40 |

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| 31280 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31255* and *31265*, tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $155.85 **Benefit:** 75% = $116.90 85% = $132.50 |
| 31281 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*, *where previous excision was performed by the same practitioner*, where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $156.40 **Benefit:** 75% = $117.30 85% = $132.95 |
| 31282 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*, *performed by a practitioner other than the practitioner who provided the previous treatment*, where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $156.40 **Benefit:** 75% = $117.30 85% = $132.95 |
| 31283 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items *31255* and *31265*, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $156.40 **Benefit:** 75% = $117.30 85% = $132.95 |
| 31285 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05 |
| 31286 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *where previous excision was performed by the same practitioner*, where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05 |
| 31287 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *performed by a practitioner other than the practitioner who provided the previous treatment*, where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05 |
| 31288 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31270, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $212.95 **Benefit:** 75% = $159.75 85% = $181.05 |

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| 31290 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275***, **tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05 |
| 31291 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05 |
| 31292 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275,** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05 |
| 31293 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31275,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $245.90 **Benefit:** 75% = $184.45 85% = $209.05 |
| 31295 | BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT (where lesion was treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), ***performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment***, **removal from the head or neck (anterior to the sternomastoid muscles)**, where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $292.85 **Benefit:** 75% = $219.65 85% = $248.95 |
| | **TREATMENT OF MALIGNANT MELANOMA AND LOCALLY AGGRESSIVE SKIN TUMOURS**<br><br>Definitive surgical excision for items 31300-31335 is defined as "surgical removal with an adequate margin and as a result, no further surgery is indicated at that site of excision". |
| 31300 | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $319.90 **Benefit:** 75% = $239.95 85% = $271.95 |
| 31305 | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE and **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $393.50 **Benefit:** 75% = $295.15 85% = $334.50 |
| 31310 | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)*<br>**Fee:** $278.65 **Benefit:** 75% = $209.00 85% = $236.90 |

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| | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)* |
| 31315 | **Fee:** $352.50 **Benefit:** 75% = $264.40 85% = $299.65 |
| | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 and T8.24 of explanatory notes to this Category)* |
| 31320 | **Fee:** $393.50 **Benefit:** 75% = $295.15 85% = $334.50 |
| | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31300* and *31310* - tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31325 | **Fee:** $270.55 **Benefit:** 75% = $202.95 85% = $230.00 |
| | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31310* - tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31330 | **Fee:** $319.90 **Benefit:** 75% = $239.95 85% = $271.95 |
| | MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31335 | **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65 |
| | **NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item.*<br>MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, where the specimen excised is sent for histological confirmation, performed in association with excision of malignant tumour of skin covered by item **31255, 31256, 31257, 31258, 31260, 31261, 31262, 31263, 31265, 31266, 31267, 31268, 31270, 31271, 31272, 31273, 31275, 31276, 31277, 31278, 31280, 31281, 31282, 31283, 31285, 31286, 31287, 31288, 31290, 31291, 31292, 31293, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335** (Anaes.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 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.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31345 | **Fee:** $210.95 **Benefit:** 75% = $158.25 85% = $179.35 |
| | LIPOSUCTION (suction assisted lipolysis) to 1 regional area for treatment of contour problems of abdominal or upper arm or thigh fat due to repeated insulin injections, ***where the lesion is subcutaneous and 50mm or more in diameter*** (Anaes.) |
| 31346 | **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***, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>*(See para T8.23 of explanatory notes to this Category)* |
| 31350 | **Fee:** $433.35 **Benefit:** 75% = $325.05 85% = $368.35 |

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| 31355 | MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by **surgical excision**, where ***histological proof of malignancy has been obtained***, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>*(See para T8.23 of explanatory notes to this Category)*<br>**Fee:** $714.45 **Benefit:** 75% = $535.85 85% = $639.95 |
| 31400 | 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.)<br>**Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $221.90 |
| 31403 | MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)<br>**Fee:** $301.35 **Benefit:** 75% = $226.05 |
| 31406 | MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)<br>**Fee:** $502.15 **Benefit:** 75% = $376.65 85% = $427.65 |
| 31409 | PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)<br>**Fee:** $1,560.15 **Benefit:** 75% = $1,170.15 |
| 31412 | RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)<br>**Fee:** $1,921.75 **Benefit:** 75% = $1,441.35 |
| 31420 | LYMPH NODE OF NECK, biopsy of (Anaes.)<br>**Fee:** $183.90 **Benefit:** 75% = $137.95 85% = $156.35 |
| 31423 | LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)<br>*(See para T8.25 of explanatory notes to this Category)*<br>**Fee:** $401.75 **Benefit:** 75% = $301.35 85% = $341.50 |
| 31426 | LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)<br>*(See para T8.25 of explanatory notes to this Category)*<br>**Fee:** $803.45 **Benefit:** 75% = $602.60 |
| 31429 | LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.)<br>*(See para T8.25 of explanatory notes to this Category)*<br>**Fee:** $1,252.10 **Benefit:** 75% = $939.10 |
| 31432 | LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.)<br>*(See para T8.25 of explanatory notes to this Category)*<br>**Fee:** $1,339.15 **Benefit:** 75% = $1,004.40 |
| 31435 | LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.)<br>*(See para T8.25 of explanatory notes to this Category)*<br>**Fee:** $984.30 **Benefit:** 75% = $738.25 |
| 31438 | LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.)<br>*(See para T8.25 of explanatory notes to this Category)*<br>**Fee:** $1,560.15 **Benefit:** 75% = $1,170.15 |
| 31441 | (*see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band*)<br><br>LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes.)<br>**Fee:** $251.70 **Benefit:** 75% = $188.80 85% = $213.95 |
| 31450 | LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.)<br>**Fee:** $406.65 **Benefit:** 75% = $305.00 |

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| 31452 | LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.)<br>**Fee:** $711.50 **Benefit:** 75% = $533.65 |
| 31454 | LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 |
| 31456 | 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.)<br>**Fee:** $245.55 **Benefit:** 75% = $184.20 |
| 31458 | 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.)<br>**Fee:** $294.65 **Benefit:** 75% = $221.00 |
| 31460 | PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.)<br>**Fee:** $357.00 **Benefit:** 75% = $267.75 |
| 31462 | OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 31464 | 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.)<br>*(See para T8.20 of explanatory notes to this Category)*<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 |
| 31466 | 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.)<br>*(See para T8.20 of explanatory notes to this Category)*<br>**Fee:** $1,306.95 **Benefit:** 75% = $980.25 |
| 31468 | PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.)<br>**Fee:** $1,435.85 **Benefit:** 75% = $1,076.90 |
| 31470 | LAPAROSCOPIC SPLENECTOMY (Anaes.) (Assist.)<br>**Fee:** $720.20 **Benefit:** 75% = $540.15 |
| 31472 | CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.)<br>**Fee:** $1,169.80 **Benefit:** 75% = $877.35 |
| 31500 | BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.)<br>*(See para T8.26 of explanatory notes to this Category)*<br>**Fee:** $260.05 **Benefit:** 75% = $195.05 85% = $221.05 |
| 31503 | BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.)<br>*(See para T8.26 of explanatory notes to this Category)*<br>**Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75 |
| 31506 | BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.)<br>*(See para T8.26 of explanatory notes to this Category)*<br>**Fee:** $390.10 **Benefit:** 75% = $292.60 |
| 31509 | BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.)<br>*(See para T8.26 of explanatory notes to this Category)*<br>**Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75 |
| 31512 | BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.)<br>*(See para T8.26 of explanatory notes to this Category)*<br>**Fee:** $650.15 **Benefit:** 75% = $487.65 |

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| 31515 | BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.)<br>*(See para T8.26 of explanatory notes to this Category)*<br>**Fee:** $436.15 **Benefit:** 75% = $327.15 |
| 31518 | BREAST (female), total mastectomy (Anaes.) (Assist.)<br>**Fee:** $736.30 **Benefit:** 75% = $552.25 |
| 31521 | BREAST (male), total mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.)<br>*(See para T8.27 of explanatory notes to this Category)*<br>**Fee:** $433.50 **Benefit:** 75% = $325.15 85% = $368.50<br>**Extended Medicare Safety Net Cap:** $346.80 |
| 31524 | BREAST (female), subcutaneous mastectomy (Anaes.) (Assist.)<br>*(See para T8.27 of explanatory notes to this Category)*<br>**Fee:** $1,040.25 **Benefit:** 75% = $780.20 |
| 31527 | BREAST (male), SUBCUTANEOUS MASTECTOMY, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which 45585 applies (Anaes.) (Assist.)<br>*(See para T8.27 of explanatory notes to this Category)*<br>**Fee:** $520.20 **Benefit:** 75% = $390.15 85% = $445.70<br>**Extended Medicare Safety Net Cap:** $416.20 |
| 31530 | BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated:<br>(a) microcalcification of lesion; or<br>(b) impalpable lesion less than 1cm in diameter<br>- including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply<br>**Fee:** $595.65 **Benefit:** 75% = $446.75 85% = $521.15 |
| 31533 | FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.)<br>*(See para T8.28 of explanatory notes to this Category)*<br>**Fee:** $137.90 **Benefit:** 75% = $103.45 85% = $117.25 |
| 31536 | 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.)<br>**Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00 |
| 31539 | BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using advanced breast biopsy instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.)<br>*(See para T8.29 of explanatory notes to this Category)*<br>**Fee:** $398.80 **Benefit:** 75% = $299.10 |
| 31542 | BREAST, initial guidewire localisation of lesion, by hookwire or similar device, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to advanced breast biopsy instrumentation (ABBI), - including imaging not being a service associated with a service to which item 31536 applies (Anaes.)<br>*(See para T8.30 of explanatory notes to this Category)*<br>**Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $167.45 |
| 31545 | BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using advanced breast biopsy instrumentation (ABBI), 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.)<br>*(See para T8.29 of explanatory notes to this Category)*<br>**Fee:** $595.65 **Benefit:** 75% = $446.75 85% = $521.15 |
| 31548 | 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.)<br>**Fee:** $137.90 **Benefit:** 75% = $103.45 85% = $117.25 |

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| 31551 | BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital, excluding aftercare (Anaes.)<br>**Fee:** $216.75 **Benefit:** 75% = $162.60 85% = $184.25 |
| 31554 | BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)<br>**Fee:** $433.50 **Benefit:** 75% = $325.15 |
| 31557 | BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)<br>**Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75 |
| 31560 | ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.)<br>**Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75<br>**Extended Medicare Safety Net Cap:** $277.40 |
| 31563 | INVERTED NIPPLE, surgical eversion of (Anaes.)<br>**Fee:** $259.75 **Benefit:** 75% = $194.85 85% = $220.80 |
| 31566 | ACCESSORY NIPPLE, excision of (Anaes.)<br>**Fee:** $129.95 **Benefit:** 75% = $97.50 85% = $110.50 |
| | *SUBGROUP 2 - COLORECTAL* |
| 32000 | LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.)<br>**Fee:** $1,031.35 **Benefit:** 75% = $773.55 |
| 32003 | LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)<br>**Fee:** $1,078.80 **Benefit:** 75% = $809.10 |
| 32004 | 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.)<br>**Fee:** $1,150.35 **Benefit:** 75% = $862.80 |
| 32005 | 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.)<br>**Fee:** $1,299.55 **Benefit:** 75% = $974.70 |
| 32006 | LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.)<br>**Fee:** $1,150.35 **Benefit:** 75% = $862.80 |
| 32009 | TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.)<br>**Fee:** $1,364.60 **Benefit:** 75% = $1,023.45 |
| 32012 | TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.)<br>**Fee:** $1,507.40 **Benefit:** 75% = $1,130.55 |
| 32015 | TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $1,852.50 **Benefit:** 75% = $1,389.40 |
| 32018 | TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,570.85 **Benefit:** 75% = $1,178.15 |
| 32021 | TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.)<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 |
| 32023 | 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:<br>a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or<br>b) an unknown diagnosis<br>(Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $555.35 **Benefit:** 75% = $416.55 |

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| 32024 | RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)<br>**Fee:** $1,364.60 **Benefit:** 75% = $1,023.45 |
| 32025 | RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.)<br>**Fee:** $1,825.30 **Benefit:** 75% = $1,369.00 |
| 32026 | RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.)<br>**Fee:** $1,965.65 **Benefit:** 75% = $1,474.25 |
| 32028 | RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.)<br>**Fee:** $2,106.20 **Benefit:** 75% = $1,579.65 |
| 32029 | COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.)<br>**Fee:** $421.20 **Benefit:** 75% = $315.90 |
| 32030 | RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.)<br>**Fee:** $1,031.35 **Benefit:** 75% = $773.55 |
| 32033 | RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.)<br>**Fee:** $1,507.40 **Benefit:** 75% = $1,130.55 |
| 32036 | SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.)<br>**Fee:** $1,911.80 **Benefit:** 75% = $1,433.85 |
| 32039 | RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $1,535.05 **Benefit:** 75% = $1,151.30 |
| 32042 | RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.)<br>**Fee:** $1,293.15 **Benefit:** 75% = $969.90 |
| 32045 | RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.)<br>**Fee:** $483.95 **Benefit:** 75% = $363.00 |
| 32046 | RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.)<br>**Fee:** $747.90 **Benefit:** 75% = $560.95 |
| 32047 | PERINEAL PROCTECTOMY (Anaes.) (Assist.)<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 |
| 32051 | TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $2,316.60 **Benefit:** 75% = $1,737.45 |
| 32054 | TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $2,126.20 **Benefit:** 75% = $1,594.65 |
| 32057 | TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.)<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 |
| 32060 | ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $2,316.60 **Benefit:** 75% = $1,737.45 |

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| 32063 | ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $2,126.20 **Benefit:** 75% = $1,594.65 | |
| 32066 | ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.)<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 | |
| 32069 | ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.)<br>**Fee:** $1,713.65 **Benefit:** 75% = $1,285.25 | |
| 32072 | SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy<br>**Fee:** $47.85 **Benefit:** 75% = $35.90 85% = $40.70 | |
| 32075 | SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $75.05 **Benefit:** 75% = $56.30 85% = $63.80 | |
| 32078 | SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (Anaes.)<br>**Fee:** $168.55 **Benefit:** 75% = $126.45 85% = $143.30 | |
| 32081 | SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.)<br>**Fee:** $231.45 **Benefit:** 75% = $173.60 85% = $196.75 | |
| 32084 | FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $111.35 **Benefit:** 75% = $83.55 85% = $94.65 | |
| 32087 | Endoscopic examination of the colon up to the hepatic flexure by FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of, not being a service to which item 32078 applies (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00 | |
| 32090 | FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $334.35 **Benefit:** 75% = $250.80 85% = $284.20 | |
| 32093 | Endoscopic examination of the colon beyond the hepatic flexure by FIBREOPTIC COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS, or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $469.20 **Benefit:** 75% = $351.90 85% = $398.85 | |
| 32094 | ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $551.85 **Benefit:** 75% = $413.90 | |
| 32095 | ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.)<br>*(See para T8.17 of explanatory notes to this Category)*<br>**Fee:** $127.80 **Benefit:** 75% = $95.85 85% = $108.65 | |
| 32096 | RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.)<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45 | |
| 32099 | RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.)<br>**Fee:** $333.20 **Benefit:** 75% = $249.90 | |

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| 32102 | RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.)<br>**Fee:** $634.70 **Benefit:** 75% = $476.05 |
| 32103 | RECTAL TUMOUR, of less than 4 cm in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.)<br>*(See para T8.17 and T8.31 of explanatory notes to this Category)*<br>**Fee:** $772.30 **Benefit:** 75% = $579.25 |
| 32104 | RECTAL TUMOUR, of 4 cm or greater in diameter, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy or by local excision, other than a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.)<br>*(See para T8.17 and T8.31 of explanatory notes to this Category)*<br>**Fee:** $999.65 **Benefit:** 75% = $749.75 |
| 32105 | ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.)<br>**Fee:** $483.95 **Benefit:** 75% = $363.00 85% = $411.40 |
| 32106 | ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using rectoscopy incorporating either 3 dimensional or 2 dimensional optic viewing systems, if removal is unable to be performed during colonoscopy and if removal requires dissection within the peritoneal cavity, other than a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.)<br>*(See para T8.17 and T8.31 of explanatory notes to this Category)*<br>**Fee:** $1,364.60 **Benefit:** 75% = $1,023.45 85% = $1,290.10 |
| 32108 | RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.)<br>**Fee:** $999.65 **Benefit:** 75% = $749.75 |
| 32111 | RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.)<br>**Fee:** $634.70 **Benefit:** 75% = $476.05 |
| 32112 | RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.)<br>**Fee:** $772.30 **Benefit:** 75% = $579.25 |
| 32114 | RECTAL STRICTURE, per anal release of (Anaes.)<br>**Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30 |
| 32115 | RECTAL STRICTURE, dilatation of (Anaes.)<br>**Fee:** $126.85 **Benefit:** 75% = $95.15 |
| 32117 | RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.)<br>**Fee:** $999.65 **Benefit:** 75% = $749.75 |
| 32120 | RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.)<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 |
| 32123 | ANAL STRICTURE, anoplasty for (Anaes.) (Assist.)<br>**Fee:** $333.20 **Benefit:** 75% = $249.90 85% = $283.25 |
| 32126 | ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.)<br>**Fee:** $483.95 **Benefit:** 75% = $363.00 |
| 32129 | ANAL SPHINCTER, direct repair of (Anaes.) (Assist.)<br>**Fee:** $634.70 **Benefit:** 75% = $476.05 |
| 32131 | RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.)<br>**Fee:** $533.60 **Benefit:** 75% = $400.20 |
| 32132 | HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.)<br>**Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 |
| 32135 | HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.)<br>**Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40 |

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| 32138 | HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.)<br>**Fee:** $367.75 **Benefit:** 75% = $275.85 85% = $312.60 |
| 32139 | HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.)<br>**Fee:** $367.75 **Benefit:** 75% = $275.85 |
| 32142 | ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.)<br>**Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40 |
| 32145 | ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $135.05 **Benefit:** 75% = $101.30 85% = $114.80 |
| 32147 | PERIANAL THROMBOSIS, incision of (Anaes.)<br>**Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 |
| 32150 | OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.)<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45 |
| 32153 | ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $70.10 **Benefit:** 75% = $52.60 |
| 32156 | FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.)<br>**Fee:** $131.75 **Benefit:** 75% = $98.85 85% = $112.00 |
| 32159 | ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)<br>**Fee:** $333.20 **Benefit:** 75% = $249.90 |
| 32162 | ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.)<br>**Fee:** $483.95 **Benefit:** 75% = $363.00 |
| 32165 | ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.)<br>**Fee:** $634.70 **Benefit:** 75% = $476.05 85% = $560.20 |
| 32166 | ANAL FISTULA - readjustment of Seton (Anaes.)<br>**Fee:** $206.20 **Benefit:** 75% = $154.65 85% = $175.30 |
| 32168 | FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.)<br>**Fee:** $131.75 **Benefit:** 75% = $98.85 |
| 32171 | ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $88.80 **Benefit:** 75% = $66.60 |
| 32174 | INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)<br>**Fee:** $88.80 **Benefit:** 75% = $66.60 85% = $75.50 |
| 32175 | INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.)<br>**Fee:** $162.65 **Benefit:** 75% = $122.00 |
| 32177 | ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)<br>**Fee:** $174.25 **Benefit:** 75% = $130.70 |
| 32180 | ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.)<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 |
| 32183 | INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.)<br>**Fee:** $561.65 **Benefit:** 75% = $421.25 |

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| 32186 | COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.)<br>**Fee:** $561.65 **Benefit:** 75% = $421.25 |
| 32200 | DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35 |
| 32203 | ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.)<br>**Fee:** $635.00 **Benefit:** 75% = $476.25 |
| 32206 | STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.)<br>**Fee:** $573.70 **Benefit:** 75% = $430.30 |
| 32209 | ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.)<br>**Fee:** $921.95 **Benefit:** 75% = $691.50 |
| 32210 | GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.)<br>**Fee:** $255.45 **Benefit:** 75% = $191.60 85% = $217.15 |
| 32212 | ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.)<br>**Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85 |
| 32213 | SACRAL NERVE LEAD(S), placement of, percutaneous using fluoroscopic guidance, or open, and intraoperative test stimulation, for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment (Anaes.)<br>**Fee:** $660.95 **Benefit:** 75% = $495.75 |
| 32214 | NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, using fluoroscopic guidance (Anaes.) (Assist.)<br>**Fee:** $334.00 **Benefit:** 75% = $250.50 |
| 32215 | SACRAL NERVE ELECTRODE(S), management, adjustment, and electronic programming of neurostimulator by a medical practitioner, for the management of faecal incontinence - each day<br>**Fee:** $125.40 **Benefit:** 75% = $94.05 85% = $106.60 |
| 32216 | SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Anaes.)<br>**Fee:** $593.55 **Benefit:** 75% = $445.20 |
| 32217 | NEUROSTIMULATOR or RECEIVER, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.)<br>**Fee:** $156.30 **Benefit:** 75% = $117.25 |
| 32218 | SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.)<br>**Fee:** $156.30 **Benefit:** 75% = $117.25 |
| 32220 | Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed (Anaes.) (Assist.)<br>**Fee:** $903.90 **Benefit:** 75% = $677.95 85% = $829.40 |
| 32221 | Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed (Anaes.) (Assist.)<br>**Fee:** $903.90 **Benefit:** 75% = $677.95 85% = $829.40 |

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| | *SUBGROUP 3 - VASCULAR* |
| | *VARICOSE VEINS* |
| 32500 | 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 after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.)<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $109.80 **Benefit:** 75% = $82.35 85% = $93.35<br>**Extended Medicare Safety Net Cap:** $120.80 |
| 32501 | 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 after-care) where it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination ***- and that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period***<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $109.80 **Benefit:** 75% = $82.35 85% = $93.35<br>**Extended Medicare Safety Net Cap:** $87.85 |
| 32504 | 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.)<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55<br>**Extended Medicare Safety Net Cap:** $214.15 |
| 32507 | 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.)<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $533.60 **Benefit:** 75% = $400.20 85% = $459.10<br>**Extended Medicare Safety Net Cap:** $426.90 |
| 32508 | 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.)<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $533.60 **Benefit:** 75% = $400.20 |
| 32511 | 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.)<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $793.30 **Benefit:** 75% = $595.00 |
| 32514 | 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.)<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $926.80 **Benefit:** 75% = $695.10 |
| 32517 | 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.)<br>*(See para T8.32 of explanatory notes to this Category)*<br>**Fee:** $1,193.40 **Benefit:** 75% = $895.05 |
| **Amend**<br>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, where 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, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.)<br>*(See para T8.33 of explanatory notes to this Category)*<br>**Fee:** $533.60 **Benefit:** 75% = $400.20 85% = $459.10<br>**Extended Medicare Safety Net Cap:** $80.05 |

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| **Amend**<br>32522 | 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 a laser probe introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both) but not including radiofrequency diathermy or radiofrequency ablation, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.)<br>*(See para T8.33 of explanatory notes to this Category)*<br>**Fee:** $793.30 **Benefit:** 75% = $595.00 85% = $718.80<br>**Extended Medicare Safety Net Cap:** $79.35 |
| **EMSN**<br>**New**<br>32523 | 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 radiofrequency catheter introduced by an endovenous catheter, where 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, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.)<br>*(See para T8.33 of explanatory notes to this Category)*<br>**Fee:** $533.60 **Benefit:** 75% = $400.20 85% = $459.10<br>**Extended Medicare Safety Net Cap:** $80.05 |
| **EMSN**<br>**New**<br>32526 | 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 a radiofrequency catheter introduced by an endovenous catheter, where it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer, including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both), but not including endovenous laser therapy, and not provided on the same occasion as a service described in any of items 32500, 32501, 32504 or 32507 (Anaes.)<br>*(See para T8.33 of explanatory notes to this Category)*<br>**Fee:** $793.30 **Benefit:** 75% = $595.00 85% = $718.80<br>**Extended Medicare Safety Net Cap:** $79.35 |
| | *BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE* |
| 32700 | ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.)<br>**Fee:** $1,436.30 **Benefit:** 75% = $1,077.25 |
| 32703 | INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |
| 32708 | AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.)<br>**Fee:** $1,421.35 **Benefit:** 75% = $1,066.05 |
| 32710 | AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.)<br>**Fee:** $1,579.30 **Benefit:** 75% = $1,184.50 |
| 32711 | AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.)<br>**Fee:** $1,737.25 **Benefit:** 75% = $1,302.95 |
| 32712 | ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.)<br>**Fee:** $1,255.80 **Benefit:** 75% = $941.85 |
| 32715 | AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.)<br>**Fee:** $1,255.80 **Benefit:** 75% = $941.85 |
| 32718 | FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |
| 32721 | RENAL ARTERY, bypass grafting to (Anaes.) (Assist.)<br>**Fee:** $1,887.35 **Benefit:** 75% = $1,415.55 |
| 32724 | RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.)<br>**Fee:** $2,143.10 **Benefit:** 75% = $1,607.35 |
| 32730 | MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.)<br>**Fee:** $1,624.30 **Benefit:** 75% = $1,218.25 |

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| 32733 | MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.)<br>**Fee:** $1,887.35 **Benefit:** 75% = $1,415.55 |
| 32736 | INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.)<br>**Fee:** $413.55 **Benefit:** 75% = $310.20 |
| 32739 | FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,293.40 **Benefit:** 75% = $970.05 |
| 32742 | FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.)<br>**Fee:** $1,481.50 **Benefit:** 75% = $1,111.15 |
| 32745 | FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.)<br>**Fee:** $1,691.95 **Benefit:** 75% = $1,269.00 |
| 32748 | FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.)<br>**Fee:** $1,834.80 **Benefit:** 75% = $1,376.10 |
| 32751 | FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |
| 32754 | FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.)<br>**Fee:** $1,481.50 **Benefit:** 75% = $1,111.15 |
| 32757 | FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.)<br>**Fee:** $413.55 **Benefit:** 75% = $310.20 |
| 32760 | VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 |
| 32763 | ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |
| 32766 | ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $789.65 **Benefit:** 75% = $592.25 |
| 32769 | ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.)<br>**Fee:** $273.65 **Benefit:** 75% = $205.25 |
| | *BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS* |
| 33050 | BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.)<br>**Fee:** $1,455.30 **Benefit:** 75% = $1,091.50 |
| 33055 | BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.)<br>**Fee:** $1,167.05 **Benefit:** 75% = $875.30 |
| 33070 | ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)<br>**Fee:** $842.00 **Benefit:** 75% = $631.50 85% = $767.50 |
| 33075 | ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)<br>**Fee:** $1,071.05 **Benefit:** 75% = $803.30 |

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| 33080 | INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)<br>**Fee:** $1,307.45 **Benefit:** 75% = $980.60 |
| 33100 | ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.)<br>**Fee:** $1,436.30 **Benefit:** 75% = $1,077.25 85% = $1,361.80 |
| 33103 | THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.)<br>**Fee:** $2,015.30 **Benefit:** 75% = $1,511.50 |
| 33109 | THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)<br>**Fee:** $2,436.50 **Benefit:** 75% = $1,827.40 85% = $2,362.00 |
| 33112 | SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.)<br>**Fee:** $2,113.10 **Benefit:** 75% = $1,584.85 |
| 33115 | INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.)<br>**Fee:** $1,421.35 **Benefit:** 75% = $1,066.05 |
| 33116 | INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)<br>**Fee:** $1,399.00 **Benefit:** 75% = $1,049.25 85% = $1,324.50 |
| 33118 | INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.)<br>**Fee:** $1,579.30 **Benefit:** 75% = $1,184.50 |
| 33119 | INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)<br>**Fee:** $1,554.55 **Benefit:** 75% = $1,165.95 85% = $1,480.05 |
| 33121 | INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)<br>**Fee:** $1,737.25 **Benefit:** 75% = $1,302.95 |
| 33124 | ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.)<br>**Fee:** $1,210.80 **Benefit:** 75% = $908.10 |
| 33127 | ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 85% = $1,512.25 |
| 33130 | ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.)<br>**Fee:** $1,383.65 **Benefit:** 75% = $1,037.75 |
| 33133 | ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.)<br>**Fee:** $1,037.65 **Benefit:** 75% = $778.25 |
| 33136 | FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.)<br>**Fee:** $2,616.75 **Benefit:** 75% = $1,962.60 |
| 33139 | FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 33142 | FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)<br>**Fee:** $1,481.50 **Benefit:** 75% = $1,111.15 85% = $1,407.00 |
| 33145 | RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)<br>**Fee:** $2,549.20 **Benefit:** 75% = $1,911.90 |
| 33148 | RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)<br>**Fee:** $3,165.80 **Benefit:** 75% = $2,374.35 |
| 33151 | RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)<br>**Fee:** $3,007.90 **Benefit:** 75% = $2,255.95 |

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| 33154 | RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.)<br>**Fee:** $2,225.90 **Benefit:** 75% = $1,669.45 |
| 33157 | RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)<br>**Fee:** $2,481.50 **Benefit:** 75% = $1,861.15 |
| 33160 | RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.)<br>**Fee:** $2,481.50 **Benefit:** 75% = $1,861.15 |
| 33163 | RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)<br>**Fee:** $2,105.70 **Benefit:** 75% = $1,579.30 |
| 33166 | RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.)<br>**Fee:** $2,105.70 **Benefit:** 75% = $1,579.30 85% = $2,031.20 |
| 33169 | RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)<br>**Fee:** $1,639.35 **Benefit:** 75% = $1,229.55 |
| 33172 | ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)<br>**Fee:** $1,278.35 **Benefit:** 75% = $958.80 |
| 33175 | RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)<br>**Fee:** $1,178.10 **Benefit:** 75% = $883.60 |
| 33178 | RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)<br>**Fee:** $1,498.20 **Benefit:** 75% = $1,123.65 |
| 33181 | RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)<br>**Fee:** $1,831.70 **Benefit:** 75% = $1,373.80 |
| | *ENDARTERECTOMY AND ARTERIAL PATCH* |
| 33500 | ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.)<br>**Fee:** $1,135.40 **Benefit:** 75% = $851.55 |
| 33506 | INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.)<br>**Fee:** $1,270.90 **Benefit:** 75% = $953.20 |
| 33509 | AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.)<br>**Fee:** $1,421.35 **Benefit:** 75% = $1,066.05 |
| 33512 | AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.)<br>**Fee:** $1,579.30 **Benefit:** 75% = $1,184.50 |
| 33515 | AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.)<br>**Fee:** $1,737.25 **Benefit:** 75% = $1,302.95 |
| 33518 | ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.)<br>**Fee:** $1,270.90 **Benefit:** 75% = $953.20 85% = $1,196.40 |
| 33521 | ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.)<br>**Fee:** $1,376.10 **Benefit:** 75% = $1,032.10 |
| 33524 | RENAL ARTERY, endarterectomy of (Anaes.) (Assist.)<br>**Fee:** $1,624.30 **Benefit:** 75% = $1,218.25 |

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| 33527 | RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.)<br>**Fee:** $1,887.35 **Benefit:** 75% = $1,415.55 |
| 33530 | COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)<br>**Fee:** $1,624.30 **Benefit:** 75% = $1,218.25 |
| 33533 | COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)<br>**Fee:** $1,887.35 **Benefit:** 75% = $1,415.55 |
| 33536 | INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.)<br>**Fee:** $1,346.10 **Benefit:** 75% = $1,009.60 |
| 33539 | ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.)<br>**Fee:** $970.05 **Benefit:** 75% = $727.55 |
| 33542 | EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.)<br>**Fee:** $1,383.65 **Benefit:** 75% = $1,037.75 |
| 33545 | ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.)<br>*(See para T8.36 of explanatory notes to this Category)*<br>**Fee:** $273.65 **Benefit:** 75% = $205.25 |
| 33548 | ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.)<br>*(See para T8.36 of explanatory notes to this Category)*<br>**Fee:** $556.60 **Benefit:** 75% = $417.45 |
| 33551 | VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.)<br>*(See para T8.36 of explanatory notes to this Category)*<br>**Fee:** $273.65 **Benefit:** 75% = $205.25 |
| 33554 | ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.)<br>**Fee:** $272.40 **Benefit:** 75% = $204.30 |
| | *EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA* |
| 33800 | EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.)<br>**Fee:** $1,180.60 **Benefit:** 75% = $885.45 85% = $1,106.10 |
| 33803 | EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.)<br>**Fee:** $1,128.05 **Benefit:** 75% = $846.05 |
| 33806 | Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Anaes.) (Assist.)<br>**Fee:** $812.15 **Benefit:** 75% = $609.15 85% = $737.65 |
| 33810 | INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.)<br>**Fee:** $592.45 **Benefit:** 75% = $444.35 85% = $517.95 |
| 33811 | INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.)<br>**Fee:** $1,763.80 **Benefit:** 75% = $1,322.85 |
| 33812 | THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.)<br>**Fee:** $932.45 **Benefit:** 75% = $699.35 85% = $857.95 |
| 33815 | MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)<br>**Fee:** $857.30 **Benefit:** 75% = $643.00 |
| 33818 | MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,000.15 **Benefit:** 75% = $750.15 |

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| 33821 | MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)<br>**Fee:** $1,143.00 **Benefit:** 75% = $857.25 |
| 33824 | MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.)<br>**Fee:** $1,090.35 **Benefit:** 75% = $817.80 |
| 33827 | MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,278.35 **Benefit:** 75% = $958.80 |
| 33830 | MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.)<br>**Fee:** $1,466.30 **Benefit:** 75% = $1,099.75 |
| 33833 | MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.)<br>**Fee:** $1,331.15 **Benefit:** 75% = $998.40 |
| 33836 | MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 33839 | MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.)<br>**Fee:** $1,857.40 **Benefit:** 75% = $1,393.05 |
| 33842 | ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.)<br>**Fee:** $917.40 **Benefit:** 75% = $688.05 |
| 33845 | LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.)<br>**Fee:** $639.20 **Benefit:** 75% = $479.40 |
| 33848 | EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.)<br>**Fee:** $639.20 **Benefit:** 75% = $479.40 |
| | *LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS* |
| 34100 | MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.)<br>**Fee:** $707.00 **Benefit:** 75% = $530.25 |
| 34103 | GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.)<br>**Fee:** $413.55 **Benefit:** 75% = $310.20 |
| 34106 | ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.)<br>**Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $247.95<br>**Extended Medicare Safety Net Cap:** $233.40 |
| 34109 | TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.)<br>**Fee:** $338.35 **Benefit:** 75% = $253.80 85% = $287.60 |
| 34112 | ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.)<br>**Fee:** $857.30 **Benefit:** 75% = $643.00 |
| 34115 | ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.)<br>**Fee:** $970.05 **Benefit:** 75% = $727.55 |
| 34118 | ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.)<br>**Fee:** $1,383.65 **Benefit:** 75% = $1,037.75 85% = $1,309.15 |

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| 34121 | ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)<br>**Fee:** $1,105.35 **Benefit:** 75% = $829.05 |
| 34124 | ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)<br>**Fee:** $1,210.80 **Benefit:** 75% = $908.10 |
| 34127 | ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 34130 | SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.)<br>**Fee:** $496.30 **Benefit:** 75% = $372.25 85% = $421.90 |
| 34133 | SCALENOTOMY (Anaes.) (Assist.)<br>**Fee:** $556.60 **Benefit:** 75% = $417.45 |
| 34136 | FIRST RIB, resection of portion of (Anaes.) (Assist.)<br>**Fee:** $894.75 **Benefit:** 75% = $671.10 |
| 34139 | CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)<br>**Fee:** $894.75 **Benefit:** 75% = $671.10 |
| 34142 | COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $1,105.35 **Benefit:** 75% = $829.05 |
| 34145 | POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.)<br>**Fee:** $804.65 **Benefit:** 75% = $603.50 |
| 34148 | CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.)<br>**Fee:** $1,436.30 **Benefit:** 75% = $1,077.25 |
| 34151 | CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)<br>**Fee:** $1,962.65 **Benefit:** 75% = $1,472.00 |
| 34154 | RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.)<br>**Fee:** $2,338.75 **Benefit:** 75% = $1,754.10 85% = $2,264.25 |
| 34157 | NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |
| 34160 | AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.)<br>**Fee:** $2,225.90 **Benefit:** 75% = $1,669.45 |
| 34163 | AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.)<br>**Fee:** $2,857.55 **Benefit:** 75% = $2,143.20 |
| 34166 | AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.)<br>**Fee:** $2,857.55 **Benefit:** 75% = $2,143.20 |
| 34169 | INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 34172 | INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.)<br>**Fee:** $1,293.40 **Benefit:** 75% = $970.05 |
| 34175 | INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |

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| | *OPERATIONS FOR VASCULAR ACCESS* |
| 34500 | ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.)<br>**Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15 |
| 34503 | ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.)<br>**Fee:** $413.55 **Benefit:** 75% = $310.20 |
| 34506 | ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.)<br>**Fee:** $210.45 **Benefit:** 75% = $157.85 |
| 34509 | ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.)<br>**Fee:** $977.55 **Benefit:** 75% = $733.20 |
| 34512 | ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.)<br>**Fee:** $1,075.40 **Benefit:** 75% = $806.55 |
| 34515 | ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.)<br>**Fee:** $767.00 **Benefit:** 75% = $575.25 |
| 34518 | STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.)<br>**Fee:** $1,285.75 **Benefit:** 75% = $964.35 |
| 34521 | INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.)<br>**Fee:** $789.95 **Benefit:** 75% = $592.50 |
| 34524 | ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.)<br>**Fee:** $413.55 **Benefit:** 75% = $310.20 |
| 34527 | CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes.)<br>**Fee:** $551.60 **Benefit:** 75% = $413.70 85% = $477.10 |
| 34528 | CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes.)<br>**Fee:** $272.40 **Benefit:** 75% = $204.30 85% = $231.55 |
| 34530 | HICKMAN OR BROVIAC CATHETER, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital or approved day-hospital (Anaes.)<br>**Fee:** $204.25 **Benefit:** 75% = $153.20 85% = $173.65 |
| 34533 | ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,240.65 **Benefit:** 75% = $930.50 85% = $1,166.15 |
| 34538 | CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.)<br>**Fee:** $272.40 **Benefit:** 75% = $204.30 85% = $231.55 |
| 34539 | TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital (Anaes.)<br>**Fee:** $204.25 **Benefit:** 75% = $153.20 85% = $173.65 |
| | *COMPLEX VENOUS OPERATIONS* |
| 34800 | INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.)<br>**Fee:** $812.15 **Benefit:** 75% = $609.15 85% = $737.65 |
| 34803 | INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.)<br>**Fee:** $1,789.85 **Benefit:** 75% = $1,342.40 |

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| 34806 | CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.)<br>**Fee:** $970.05 **Benefit:** 75% = $727.55 |
| 34809 | SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.)<br>**Fee:** $970.05 **Benefit:** 75% = $727.55 |
| 34812 | VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.)<br>**Fee:** $1,173.05 **Benefit:** 75% = $879.80 |
| 34815 | VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.)<br>*(See para T8.36 of explanatory notes to this Category)*<br>**Fee:** $970.05 **Benefit:** 75% = $727.55 |
| 34818 | VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.)<br>**Fee:** $1,067.80 **Benefit:** 75% = $800.85 |
| 34821 | VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.)<br>**Fee:** $1,451.45 **Benefit:** 75% = $1,088.60 85% = $1,376.95 |
| 34824 | EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.)<br>**Fee:** $496.30 **Benefit:** 75% = $372.25 |
| 34827 | EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.)<br>**Fee:** $601.65 **Benefit:** 75% = $451.25 |
| 34830 | EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.)<br>**Fee:** $707.00 **Benefit:** 75% = $530.25 85% = $632.50 |
| 34833 | EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.)<br>**Fee:** $917.40 **Benefit:** 75% = $688.05 |
| | *SYMPATHECTOMY* |
| 35000 | LUMBAR SYMPATHECTOMY (Anaes.) (Assist.)<br>**Fee:** $707.00 **Benefit:** 75% = $530.25 85% = $632.50 |
| 35003 | CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.)<br>**Fee:** $917.40 **Benefit:** 75% = $688.05 |
| 35006 | CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.)<br>**Fee:** $1,150.55 **Benefit:** 75% = $862.95 |
| 35009 | LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.)<br>**Fee:** $894.75 **Benefit:** 75% = $671.10 |
| 35012 | SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)<br>**Fee:** $707.00 **Benefit:** 75% = $530.25 |
| | *DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE* |
| 35100 | ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.)<br>**Fee:** $368.55 **Benefit:** 75% = $276.45 |
| 35103 | ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.)<br>**Fee:** $234.55 **Benefit:** 75% = $175.95 85% = $199.40 |

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| | *MISCELLANEOUS VASCULAR PROCEDURES* |
| 35200 | OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes.)<br>**Fee:** $171.50 **Benefit:** 75% = $128.65 |
| 35202 | MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.)<br>**Fee:** $817.10 **Benefit:** 75% = $612.85 |
| | *ENDOVASCULAR INTERVENTIONAL PROCEDURES* |
| 35300 | TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $515.35 **Benefit:** 75% = $386.55 85% = $440.85 |
| 35303 | TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $660.80 **Benefit:** 75% = $495.60 85% = $586.30 |
| 35306 | TRANSLUMINAL STENT INSERTION including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $609.90 **Benefit:** 75% = $457.45 85% = $535.40 |
| 35307 | TRANSLUMINAL STENT INSERTION, 1 or more stents (not drug-eluting), with or without associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or without the use of an embolic protection device, in patients who:<br>- meet the indications for carotid endarterectomy; and<br>- have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy,<br>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.37 of explanatory notes to this Category)*<br>**Fee:** $1,121.15 **Benefit:** 75% = $840.90 |
| 35309 | TRANSLUMINAL STENT INSERTION including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $762.35 **Benefit:** 75% = $571.80 85% = $687.85 |
| 35312 | PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $864.05 **Benefit:** 75% = $648.05 |
| 35315 | PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $864.05 **Benefit:** 75% = $648.05 |
| 35317 | 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.)<br>*(See para T8.38 of explanatory notes to this Category)*<br>**Fee:** $355.80 **Benefit:** 75% = $266.85 85% = $302.45 |
| 35319 | 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.)<br>**Fee:** $637.80 **Benefit:** 75% = $478.35 85% = $563.30 |
| 35320 | 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.)<br>**Fee:** $856.70 **Benefit:** 75% = $642.55 85% = $782.20 |

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| 35321 | 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.)<br>*(See para T8.39 of explanatory notes to this Category)*<br>**Fee:** $813.30 **Benefit:** 75% = $610.00 85% = $738.80 |
| 35324 | ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $304.95 **Benefit:** 75% = $228.75 |
| 35327 | ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $408.70 **Benefit:** 75% = $306.55 |
| 35330 | INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $515.35 **Benefit:** 75% = $386.55 85% = $440.85 |
| 35331 | RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.)<br>**Fee:** $592.45 **Benefit:** 75% = $444.35 |
| 35360 | Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare<br>***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.)<br>**Fee:** $828.20 **Benefit:** 75% = $621.15 |
| 35361 | Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare<br>***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.)<br>**Fee:** $710.30 **Benefit:** 75% = $532.75 |
| 35362 | Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare<br>***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.)<br>**Fee:** $592.45 **Benefit:** 75% = $444.35 |
| 35363 | Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare<br>***(foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.)<br>**Fee:** $474.65 **Benefit:** 75% = $356.00 |
| | *INTERVENTIONAL RADIOLOGY PROCEDURES* |
| 35404 | DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies<br>The procedure must be performed by a specialist or consultant physician recognised in the specialties of nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only.<br>*(See para T8.40 of explanatory notes to this Category)*<br>**Fee:** $346.60 **Benefit:** 75% = $259.95 |
| 35406 | Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies<br>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.40 of explanatory notes to this Category)*<br>**Fee:** $813.30 **Benefit:** 75% = $610.00 |

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| 35408 | Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies<br>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.40 of explanatory notes to this Category)*<br>**Fee:** $610.10 **Benefit:** 75% = $457.60 |
| 35410 | UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.34 of explanatory notes to this Category)*<br>**Fee:** $813.30 **Benefit:** 75% = $610.00 85% = $738.80 |
| 35412 | Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including intra-operative imaging, but in association with pre-operative diagnostic imaging items 60009 and either 60072, 60075 or 60078, including aftercare (Anaes.) (Assist.)<br>*(See para T8.35 of explanatory notes to this Category)*<br>**Fee:** $2,857.55 **Benefit:** 75% = $2,143.20 85% = $2,783.05 |
| | *SUBGROUP 4 - GYNAECOLOGICAL* |
| 35500 | GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $81.30 **Benefit:** 75% = $61.00 85% = $69.15 |
| 35502 | INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopathic menorrhagia, AND ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $80.15 **Benefit:** 75% = $60.15 85% = $68.15 |
| 35503 | INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $53.55 **Benefit:** 75% = $40.20 85% = $45.55 |
| 35506 | INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $53.70 **Benefit:** 75% = $40.30 85% = $45.65 |
| 35507 | VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.)<br>**Fee:** $174.45 **Benefit:** 75% = $130.85 85% = $148.30 |
| 35508 | VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) (Assist.)<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45 |
| 35509 | HYMENECTOMY (Anaes.)<br>**Fee:** $89.45 **Benefit:** 75% = $67.10 85% = $76.05 |
| 35512 G<br>35513 S | BARTHOLIN'S CYST, excision of (Anaes.)<br>**Fee:** $179.40 **Benefit:** 75% = $134.55 85% = $152.50<br>**Fee:** $221.70 **Benefit:** 75% = $166.30 85% = $188.45 |
| 35516 G<br>35517 S | BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.)<br>**Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90<br>**Fee:** $146.00 **Benefit:** 75% = $109.50 85% = $124.10 |
| 35518 | OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in premenopausal women and at least 2cm in diameter in postmenopausal women, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.)<br>**Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70 |
| 35520 | BARTHOLIN'S ABSCESS, incision of (Anaes.)<br>**Fee:** $58.30 **Benefit:** 75% = $43.75 85% = $49.60 |

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| 35523 | URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.)<br>**Fee:** $58.30 **Benefit:** 75% = $43.75 85% = $49.60 |
| 35526 G<br>35527 S | URETHRAL CARUNCLE, excision of (Anaes.)<br>**Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90<br>**Fee:** $146.00 **Benefit:** 75% = $109.50 85% = $124.10 |
| 35530 | CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.)<br>**Fee:** $269.85 **Benefit:** 75% = $202.40 |
| 35533 | VULVOPLASTY or LABIOPLASTY, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes.)<br>**Fee:** $349.85 **Benefit:** 75% = $262.40 85% = $297.40<br>**Extended Medicare Safety Net Cap:** $279.90 |
| 35536 | VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.)<br>**Fee:** $348.45 **Benefit:** 75% = $261.35 85% = $296.20 |
| 35539 | 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.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05 |
| 35542 | 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.)<br>**Fee:** $319.60 **Benefit:** 75% = $239.70 85% = $271.70 |
| 35545 | COLPOSCOPICALLY DIRECTED $CO^2$ LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.)<br>**Fee:** $183.60 **Benefit:** 75% = $137.70 85% = $156.10 |
| 35548 | VULVECTOMY, radical, for malignancy (Anaes.) (Assist.)<br>**Fee:** $834.05 **Benefit:** 75% = $625.55 |
| 35551 | PELVIC LYMPH GLANDS, excision of (radical) (Anaes.) (Assist.)<br>**Fee:** $683.90 **Benefit:** 75% = $512.95 |
| 35554 | VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.)<br>**Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00 |
| 35557 | VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.)<br>**Fee:** $214.50 **Benefit:** 75% = $160.90 85% = $182.35 |
| 35560 | VAGINA, partial or complete removal of (Anaes.) (Assist.)<br>**Fee:** $683.90 **Benefit:** 75% = $512.95 |
| 35561 | VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.)<br>**Fee:** $1,379.50 **Benefit:** 75% = $1,034.65 |
| 35562 | VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $1,132.60 **Benefit:** 75% = $849.45 |
| 35564 | VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.)<br>**Fee:** $522.85 **Benefit:** 75% = $392.15 |
| 35565 | VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.)<br>**Fee:** $683.90 **Benefit:** 75% = $512.95 |
| 35566 | VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.)<br>**Fee:** $397.25 **Benefit:** 75% = $297.95 |
| 35568 | SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.)<br>**Fee:** $624.60 **Benefit:** 75% = $468.45 |
| 35569 | PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.)<br>**Fee:** $160.85 **Benefit:** 75% = $120.65 85% = $136.75 |

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| 35570 | ANTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving repair of urethrocoele and cystocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.)<br>**Fee:** $553.85 **Benefit:** 75% = $415.40 |
| 35571 | POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving one or more of the following; repair of perineum, rectocoele or enterocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.)<br>**Fee:** $553.85 **Benefit:** 75% = $415.40 |
| 35572 | COLPOTOMY not being a service to which another item in this Group applies (Anaes.)<br>**Fee:** $123.80 **Benefit:** 75% = $92.85 |
| 35573 | ANTERIOR AND POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving both anterior and posterior compartment defects) with or without mesh, not being a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.)<br>**Fee:** $830.90 **Benefit:** 75% = $623.20 |
| 35577 | MANCHESTER (DONALD FOTHERGILL) OPERATION for genital prolapse, with or without mesh (Anaes.) (Assist.)<br>**Fee:** $674.50 **Benefit:** 75% = $505.90 |
| 35578 | LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)<br>**Fee:** $674.50 **Benefit:** 75% = $505.90 |
| 35595 | LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.)<br>**Fee:** $1,155.00 **Benefit:** 75% = $866.25 |
| 35596 | FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being a service to which item 37029, 37333 or 37336 applies (Anaes.) (Assist.)<br>**Fee:** $683.90 **Benefit:** 75% = $512.95 |
| 35597 | SACRAL COLPOPEXY, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Anaes.) (Assist.)<br>**Fee:** $1,473.20 **Benefit:** 75% = $1,104.90 |
| 35599 | STRESS INCONTINENCE, sling operation for, with or without mesh or tape, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.)<br>**Fee:** $674.50 **Benefit:** 75% = $505.90 |
| 35602 | STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.)<br>**Fee:** $674.50 **Benefit:** 75% = $505.90 |
| 35605 | STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.)<br>**Fee:** $365.95 **Benefit:** 75% = $274.50 85% = $311.10 |
| 35608 | CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.)<br>**Fee:** $64.00 **Benefit:** 75% = $48.00 85% = $54.40 |
| 35611 | CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.)<br>**Fee:** $64.00 **Benefit:** 75% = $48.00 85% = $54.40 |
| 35612 | CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.)<br>**Fee:** $506.00 **Benefit:** 75% = $379.50 85% = $431.50 |
| 35613 | CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.)<br>**Fee:** $404.80 **Benefit:** 75% = $303.60 |

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| 35614 | EXAMINATION OF LOWER FEMALE GENITAL TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear 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.)<br>*(See para T8.42 of explanatory notes to this Category)*<br>**Fee:** $63.90 | **Benefit:** 75% = $47.95 | 85% = $54.35 |
| 35615 | VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies<br>**Fee:** $53.70 | **Benefit:** 75% = $40.30 | 85% = $45.65 |
| 35616 | ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.)<br>**Fee:** $449.60 | **Benefit:** 75% = $337.20 | |
| 35617 G<br>35618 S | CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.)<br>**Fee:** $173.70<br>**Fee:** $218.00 | **Benefit:** 75% = $130.30<br>**Benefit:** 75% = $163.50 | 85% = $147.65<br>85% = $185.30 |
| 35620 | ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.)<br>**Fee:** $53.35 | **Benefit:** 75% = $40.05 | 85% = $45.35 |
| 35622 | ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.)<br>**Fee:** $602.45 | **Benefit:** 75% = $451.85 | |
| 35623 | HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.)<br>**Fee:** $819.25 | **Benefit:** 75% = $614.45 | |
| 35626 | HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies<br>*(See para T8.43 of explanatory notes to this Category)*<br>**Fee:** $82.80 | **Benefit:** 75% = $62.10 | 85% = $70.40 |
| 35627 | 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.)<br>**Fee:** $107.15 | **Benefit:** 75% = $80.40 | |
| 35630 | HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.)<br>**Fee:** $183.00 | **Benefit:** 75% = $137.25 | 85% = $155.55 |
| 35633 | HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.)<br>**Fee:** $218.00 | **Benefit:** 75% = $163.50 | 85% = $185.30 |
| 35634 | HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.)<br>**Fee:** $685.70 | **Benefit:** 75% = $514.30 | 85% = $611.20 |
| 35635 | HYSTEROSCOPY involving resection of the uterine septum (Anaes.)<br>**Fee:** $299.45 | **Benefit:** 75% = $224.60 | |
| 35636 | HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.)<br>**Fee:** $433.00 | **Benefit:** 75% = $324.75 | |
| 35637 | LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.)<br>**Fee:** $406.65 | **Benefit:** 75% = $305.00 | |

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| 35638 | COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.) (Assist.)<br>**Fee:** $711.50 **Benefit:** 75% = $533.65 |
| 35639 G<br>35640 S | UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)<br>*(See para T8.44 of explanatory notes to this Category)*<br>**Fee:** $134.90 **Benefit:** 75% = $101.20<br>**Fee:** $183.00 **Benefit:** 75% = $137.25 |
| 35641 | ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.)<br>**Fee:** $1,242.65 **Benefit:** 75% = $932.00 |
| 35643 | EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.)<br>**Fee:** $218.00 **Benefit:** 75% = $163.50 85% = $185.30 |
| 35644 | CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes.)<br>*(See para T8.45 of explanatory notes to this Category)*<br>**Fee:** $203.65 **Benefit:** 75% = $152.75 85% = $173.15 |
| 35645 | CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.)<br>*(See para T8.45 of explanatory notes to this Category)*<br>**Fee:** $318.70 **Benefit:** 75% = $239.05 85% = $270.90 |
| 35646 | CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital (Anaes.)<br>*(See para T8.45 of explanatory notes to this Category)*<br>**Fee:** $203.65 **Benefit:** 75% = $152.75 85% = $173.15 |
| 35647 | CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.)<br>*(See para T8.45 of explanatory notes to this Category)*<br>**Fee:** $203.65 **Benefit:** 75% = $152.75 85% = $173.15 |
| 35648 | CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.)<br>*(See para T8.45 of explanatory notes to this Category)*<br>**Fee:** $318.70 **Benefit:** 75% = $239.05 85% = $270.90 |
| 35649 | HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.)<br>**Fee:** $536.00 **Benefit:** 75% = $402.00 |
| 35653 | HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.)<br>**Fee:** $674.70 **Benefit:** 75% = $506.05 |
| 35657 | HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies<br><br>**NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.)<br>*(See para T8.46 of explanatory notes to this Category)*<br>**Fee:** $674.70 **Benefit:** 75% = $506.05 |

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| 35658 | UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.)<br>*(See para T8.47 of explanatory notes to this Category)*<br>**Fee:** $416.05 **Benefit:** 75% = $312.05 |
| 35661 | HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.)<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 |
| 35664 | RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)<br>**Fee:** $1,452.20 **Benefit:** 75% = $1,089.15 |
| 35667 | RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)<br>**Fee:** $1,234.25 **Benefit:** 75% = $925.70 |
| 35670 | HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.) (Assist.)<br>**Fee:** $1,016.30 **Benefit:** 75% = $762.25 |
| 35673 | HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.)<br>**Fee:** $757.80 **Benefit:** 75% = $568.35 |
| 35674 | ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy<br>**Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $176.70 |
| 35676 G<br>35677 S | ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)<br>**Fee:** $425.00 **Benefit:** 75% = $318.75<br>**Fee:** $536.00 **Benefit:** 75% = $402.00 |
| 35678 | ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.)<br>**Fee:** $646.25 **Benefit:** 75% = $484.70 |
| 35680 | BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.)<br>**Fee:** $582.05 **Benefit:** 75% = $436.55 85% = $507.55 |
| 35683 G<br>35684 S | UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $351.30 **Benefit:** 75% = $263.50<br>**Fee:** $471.15 **Benefit:** 75% = $353.40 |
| 35687 G<br>35688 S | STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method.<br><br>**NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.)<br>*(See para T8.46 of explanatory notes to this Category)*<br>**Fee:** $325.20 **Benefit:** 75% = $243.90<br>**Fee:** $397.25 **Benefit:** 75% = $297.95 |
| 35691 | STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section<br><br>**NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explantory note before submitting a claim***. (Anaes.) (Assist.)<br>*(See para T8.46 of explanatory notes to this Category)*<br>**Fee:** $158.70 **Benefit:** 75% = $119.05 |
| 35694 | TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)<br>**Fee:** $637.70 **Benefit:** 75% = $478.30 |

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| 35697 | MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)<br>**Fee:** $946.20 **Benefit:** 75% = $709.65 |
| 35700 | FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (Anaes.) (Assist.)<br>**Fee:** $730.05 **Benefit:** 75% = $547.55 |
| 35703 | HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure not being a service associated with a service to which another item in this Sub-group applies (Anaes.)<br>**Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40 |
| 35706 | RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.)<br>**Fee:** $67.50 **Benefit:** 75% = $50.65 85% = $57.40 |
| 35709 | FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.)<br>**Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00 |
| 35710 | FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)<br>**Fee:** $463.30 **Benefit:** 75% = $347.50 |
| 35712 G<br>35713 S | LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 1 such procedure, not being a service associated with hysterectomy (Anaes.) (Assist.)<br>**Fee:** $362.15 **Benefit:** 75% = $271.65<br>**Fee:** $452.85 **Benefit:** 75% = $339.65 |
| 35716 G<br>35717 S | LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes.) (Assist.)<br>**Fee:** $434.35 **Benefit:** 75% = $325.80<br>**Fee:** $545.30 **Benefit:** 75% = $409.00 |
| 35720 | RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.)<br>*(See para T8.57 of explanatory notes to this Category)*<br>**Fee:** $674.50 **Benefit:** 75% = $505.90 |
| 35723 | RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)<br>**Fee:** $483.10 **Benefit:** 75% = $362.35 |
| 35726 | INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)<br>**Fee:** $483.10 **Benefit:** 75% = $362.35 |
| 35729 | OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.)<br>**Fee:** $217.80 **Benefit:** 75% = $163.35 |
| 35750 | LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.)<br>**Fee:** $784.60 **Benefit:** 75% = $588.45 |
| 35753 | 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.)<br>**Fee:** $867.60 **Benefit:** 75% = $650.70 |
| 35754 | 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, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.) (Assist.)<br>**Fee:** $1,091.90 **Benefit:** 75% = $818.95 |
| 35756 | LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.)<br>**Fee:** $784.60 **Benefit:** 75% = $588.45 |

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| 35759 | 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.)<br>**Fee:** $563.30 **Benefit:** 75% = $422.50 |
| | *SUBGROUP 5 - UROLOGICAL* |
| | *GENERAL* |
| 36500 | ADRENAL GLAND, excision of partial or total (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 36502 | PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.)<br>**Fee:** $683.90 **Benefit:** 75% = $512.95 |
| 36503 | RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.)<br>**Fee:** $1,391.15 **Benefit:** 75% = $1,043.40 |
| 36506 | RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 36509 | RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.)<br>**Fee:** $782.95 **Benefit:** 75% = $587.25 |
| 36516 | NEPHRECTOMY, complete (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 36519 | NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.)<br>**Fee:** $1,291.10 **Benefit:** 75% = $968.35 |
| 36522 | NEPHRECTOMY, partial (Anaes.) (Assist.)<br>**Fee:** $1,107.95 **Benefit:** 75% = $831.00 |
| 36525 | NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.)<br>**Fee:** $1,574.45 **Benefit:** 75% = $1,180.85 |
| 36526 | NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.)<br>*(See para T8.48 of explanatory notes to this Category)*<br>**Fee:** $1,291.10 **Benefit:** 75% = $968.35 85% = $1,216.60 |
| 36527 | NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.)<br>*(See para T8.48 of explanatory notes to this Category)*<br>**Fee:** $1,593.40 **Benefit:** 75% = $1,195.05 85% = $1,518.90 |
| 36528 | NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Anaes.) (Assist.)<br>**Fee:** $1,291.10 **Benefit:** 75% = $968.35 |
| 36529 | NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Anaes.) (Assist.)<br>**Fee:** $1,593.40 **Benefit:** 75% = $1,195.05 |
| 36531 | NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.)<br>**Fee:** $1,157.85 **Benefit:** 75% = $868.40 |
| 36532 | NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.)<br>**Fee:** $1,661.85 **Benefit:** 75% = $1,246.40 |

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| 36533 | NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Anaes.) (Assist.)<br>**Fee:** $1,964.15 **Benefit:** 75% = $1,473.15 |
| 36537 | KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 |
| 36540 | NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.)<br>**Fee:** $1,107.95 **Benefit:** 75% = $831.00 85% = $1,033.45 |
| 36543 | NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.)<br>**Fee:** $1,291.10 **Benefit:** 75% = $968.35 85% = $1,216.60 |
| 36546 | EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 85% = $616.90 |
| 36549 | URETEROLITHOTOMY (Anaes.) (Assist.)<br>**Fee:** $833.10 **Benefit:** 75% = $624.85 |
| 36552 | NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 36558 | RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 85% = $575.30 |
| 36561 | RENAL BIOPSY (closed) (Anaes.)<br>**Fee:** $172.50 **Benefit:** 75% = $129.40 85% = $146.65 |
| 36564 | PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 36567 | PYELOPLASTY in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Anaes.) (Assist.)<br>**Fee:** $1,016.30 **Benefit:** 75% = $762.25 |
| 36570 | PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.)<br>**Fee:** $1,291.10 **Benefit:** 75% = $968.35 |
| 36573 | DIVIDED URETER, repair of (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 36576 | KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.) (Assist.)<br>**Fee:** $1,157.85 **Benefit:** 75% = $868.40 |
| 36579 | URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 36585 | URETER, transplantation of, into skin (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 36588 | URETER, reimplantation into bladder (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 36591 | URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.)<br>**Fee:** $1,107.95 **Benefit:** 75% = $831.00 |
| 36594 | URETER, transplantation of, into intestine (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |

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| 36597 | URETER, transplantation of, into another ureter (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 36600 | URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.)<br>**Fee:** $1,107.95 **Benefit:** 75% = $831.00 85% = $1,033.45 |
| 36603 | URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.)<br>**Fee:** $1,291.10 **Benefit:** 75% = $968.35 |
| 36604 | URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.)<br>**Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55 |
| 36605 | URETERIC STENT, insertion of, with removal of calculus from:<br>(a) the pelvicalyceal system; or<br>(b) ureter; or<br>(c) the pelvicalyceal system and ureter;<br>through a nephrostomy tube using interventional imaging techniques (Anaes.)<br>**Fee:** $690.70 **Benefit:** 75% = $518.05 |
| 36606 | INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.)<br>**Fee:** $2,315.80 **Benefit:** 75% = $1,736.85 |
| 36607 | URETERIC STENT insertion of, with baloon dilatation of:<br>(a) the pelvicalyceal system; or<br>(b) ureter; or<br>(c) the pelvicalyceal system and ureter;<br>through a nephrostomy tube using interventional imaging techniques (Anaes.)<br>**Fee:** $690.70 **Benefit:** 75% = $518.05 |
| 36608 | URETERIC STENT, exchange of, percutaneously through either the ileal conduit or bladder, using interventional imaging techniques, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.)<br>**Fee:** $267.65 **Benefit:** 75% = $200.75 |
| 36609 | INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 36612 | URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 |
| 36615 | URETEROLYSIS, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 36618 | REDUCTION URETEROPLASTY (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 |
| 36621 | CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.)<br>**Fee:** $464.50 **Benefit:** 75% = $348.40 |
| 36624 | NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.)<br>**Fee:** $558.10 **Benefit:** 75% = $418.60 85% = $483.60 |
| 36627 | NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 |
| 36630 | NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.)<br>**Fee:** $341.50 **Benefit:** 75% = $256.15 |
| 36633 | NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 85% = $667.00 |

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| 36636 | NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)<br>**Fee:** $399.90 **Benefit:** 75% = $299.95 |
| 36639 | NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.)<br>**Fee:** $833.10 **Benefit:** 75% = $624.85 |
| 36642 | NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.)<br>**Fee:** $416.45 **Benefit:** 75% = $312.35 |
| 36645 | NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.)<br>**Fee:** $1,066.30 **Benefit:** 75% = $799.75 |
| 36648 | NEPHROSCOPY, being a service to which item 36645 applies, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (Anaes.) (Assist.)<br>**Fee:** $949.60 **Benefit:** 75% = $712.20 |
| 36649 | NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.)<br>**Fee:** $267.65 **Benefit:** 75% = $200.75 85% = $227.55 |
| 36650 | NEPHROSTOMY TUBE, removal of, if the ureter has been stented with a double J ureteric stent and that stent is left in place, using interventional imaging techniques (Anaes.)<br>**Fee:** $149.70 **Benefit:** 75% = $112.30 |
| 36652 | PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 |
| 36654 | PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Assist.)<br>**Fee:** $833.10 **Benefit:** 75% = $624.85 |
| 36656 | PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.)<br>**Fee:** $1,066.30 **Benefit:** 75% = $799.75 |
| 36658 | SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal of pulse generator and leads<br>*(See para T8.49 of explanatory notes to this Category)*<br>**Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $451.90 |
| 36660 | SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of pulse generator<br>*(See para T8.49 of explanatory notes to this Category)*<br>**Fee:** $255.45 **Benefit:** 75% = $191.60 85% = $217.15 |
| 36662 | SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of leads<br>*(See para T8.49 of explanatory notes to this Category)*<br>**Fee:** $610.30 **Benefit:** 75% = $457.75 85% = $535.80 |
| | *OPERATIONS ON BLADDER* |
| 36663 | Sacral nerve lead(s), percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage:<br>a) detrusor overactivity; or<br>b) non obstructive urinary retention<br>that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.)<br>**Fee:** $660.95 **Benefit:** 75% = $495.75 |

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| 36664 | Sacral nerve lead(s), percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning) and intraoperative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of:<br>a) detrusor overactivity; or<br>b) non obstructive urinary retention<br>that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older, not being a service to which item 36663 applies (Anaes.)<br>**Fee:** $593.55 **Benefit:** 75% = $445.20 |
| 36665 | Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention – each day<br>**Fee:** $125.40 **Benefit:** 75% = $94.05 85% = $106.60 |
| 36666 | Pulse generator, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of<br>a) detrusor overactivity; or<br>b) non obstructive urinary retention<br>that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.)<br>**Fee:** $334.00 **Benefit:** 75% = $250.50 |
| 36667 | Sacral nerve lead(s), removal of, if the lead was inserted to manage:<br>a) detrusor overactivity; or<br>b) non obstructive urinary retention<br>that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.)<br>**Fee:** $156.30 **Benefit:** 75% = $117.25 |
| 36668 | Pulse generator, removal of, if the pulse generator was inserted to manage:<br>a) detrusor overactivity; or<br>b) non obstructive urinary retention<br>that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.)<br>**Fee:** $156.30 **Benefit:** 75% = $117.25 |
| 36800 | BLADDER, catheterisation of, where no other procedure is performed (Anaes.)<br>**Fee:** $27.60 **Benefit:** 75% = $20.70 85% = $23.50 |
| 36803 | URETEROSCOPY, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.) (Assist.)<br>*(See para T8.51 of explanatory notes to this Category)*<br>**Fee:** $466.35 **Benefit:** 75% = $349.80 85% = $396.40 |
| 36806 | URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 |
| 36809 | URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.)<br>**Fee:** $833.10 **Benefit:** 75% = $624.85 |
| 36811 | CYSTOSCOPY with insertion of urethral prosthesis (Anaes.)<br>**Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90 |
| 36812 | CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.)<br>**Fee:** $166.70 **Benefit:** 75% = $125.05 85% = $141.70 |
| 36815 | CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.)<br>*(See para T8.9 of explanatory notes to this Category)*<br>**Fee:** $237.90 **Benefit:** 75% = $178.45 85% = $202.25 |

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| 36818 | CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 |
| 36821 | CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.)<br>**Fee:** $323.20 **Benefit:** 75% = $242.40 85% = $274.75 |
| 36824 | CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.)<br>**Fee:** $213.15 **Benefit:** 75% = $159.90 85% = $181.20 |
| 36825 | CYSTOSCOPY, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Anaes.) (Assist.)<br>**Fee:** $581.30 **Benefit:** 75% = $436.00 |
| 36827 | CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes.)<br>**Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40 |
| 36830 | CYSTOSCOPY, with ureteric meatotomy (Anaes.)<br>**Fee:** $203.25 **Benefit:** 75% = $152.45 |
| 36833 | CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes.) (Assist.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 |
| 36836 | CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206 or 37215 applies (Anaes.)<br>**Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40 |
| 36840 | CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 applies (Anaes.)<br>**Fee:** $323.20 **Benefit:** 75% = $242.40 85% = $274.75 |
| 36842 | CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Anaes.) (Assist.)<br>**Fee:** $325.20 **Benefit:** 75% = $243.90 |
| 36845 | CYSTOSCOPY, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 85% = $616.90 |
| 36848 | CYSTOSCOPY, with resection of ureterocele (Anaes.)<br>**Fee:** $229.85 **Benefit:** 75% = $172.40 |
| 36851 | CYSTOSCOPY, with injection into bladder wall (Anaes.)<br>**Fee:** $229.85 **Benefit:** 75% = $172.40 |
| 36854 | CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.)<br>**Fee:** $466.35 **Benefit:** 75% = $349.80 |
| 36857 | ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.)<br>**Fee:** $366.45 **Benefit:** 75% = $274.85 |
| 36860 | ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.)<br>**Fee:** $166.70 **Benefit:** 75% = $125.05 85% = $141.70 |
| 36863 | LITHOLAPAXY, with or without cystoscopy (Anaes.) (Assist.)<br>**Fee:** $466.35 **Benefit:** 75% = $349.80 |
| 37000 | BLADDER, partial excision of (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 37004 | BLADDER, repair of rupture (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 |

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| 37008 | CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes.)<br>**Fee:** $416.45 **Benefit:** 75% = $312.35 85% = $354.00 |
| 37011 | SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.)<br>**Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35 |
| 37014 | BLADDER, total excision of (Anaes.) (Assist.)<br>**Fee:** $1,066.30 **Benefit:** 75% = $799.75 |
| 37020 | BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 37023 | VESICAL FISTULA, cutaneous, operation for (Anaes.)<br>**Fee:** $416.45 **Benefit:** 75% = $312.35 |
| 37026 | CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.)<br>**Fee:** $416.45 **Benefit:** 75% = $312.35 |
| 37029 | VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 37038 | VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.)<br>**Fee:** $691.75 **Benefit:** 75% = $518.85 |
| 37041 | BLADDER ASPIRATION by needle<br>**Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65 |
| 37042 | BLADDER STRESS INCONTINENCE, sling procedure for, using autologous fascial sling, including harvesting of sling, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)<br>**Fee:** $911.30 **Benefit:** 75% = $683.50 |
| 37043 | BLADDER STRESS INCONTINENCE, Stamey or similar type needle colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)<br>**Fee:** $674.50 **Benefit:** 75% = $505.90 |
| 37044 | BLADDER STRESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)<br>**Fee:** $691.75 **Benefit:** 75% = $518.85 |
| 37045 | MITROFANOFF CONTINENT VALVE, formation of (Anaes.) (Assist.)<br>**Fee:** $1,428.75 **Benefit:** 75% = $1,071.60 |
| 37047 | BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.)<br>**Fee:** $1,666.05 **Benefit:** 75% = $1,249.55 |
| 37050 | BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 37053 | BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.)<br>**Fee:** $856.70 **Benefit:** 75% = $642.55 |
| | *OPERATIONS ON PROSTATE* |
| 37200 | PROSTATECTOMY, open (Anaes.) (Assist.)<br>**Fee:** $1,016.30 **Benefit:** 75% = $762.25 |
| **Amend**<br>37201 | PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or 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 cold punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.)<br>*(See para T8.53 of explanatory notes to this Category)*<br>**Fee:** $828.85 **Benefit:** 75% = $621.65 |

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| **Amend** 37202 | PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or 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 cold punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.)<br>*(See para T8.53 of explanatory notes to this Category)*<br>**Fee:** $416.05 **Benefit:** 75% = $312.05 85% = $353.65 |
| **Amend** 37203 | PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.)<br>**Fee:** $1,042.15 **Benefit:** 75% = $781.65 |
| **Amend** 37206 | PROSTATECTOMY (endoscopic, using diathermy or cold punch), 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 or 37245 which had to be discontinued for medical reasons (Anaes.)<br>**Fee:** $558.10 **Benefit:** 75% = $418.60 |
| **Amend** 37207 | PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37245, 37321 or 37324 applies (Anaes.)<br>**Fee:** $866.45 **Benefit:** 75% = $649.85 |
| **Amend** 37208 | PROSTATE, endoscopic non-contact (side firing) visual laser ablation, 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 items 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.)<br>**Fee:** $416.05 **Benefit:** 75% = $312.05 |
| 37209 | PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.)<br>**Fee:** $1,291.10 **Benefit:** 75% = $968.35 |
| 37210 | PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.)<br>**Fee:** $1,593.40 **Benefit:** 75% = $1,195.05 |
| 37211 | PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, ***with pelvic lymphadenectomy***, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.)<br>**Fee:** $1,935.20 **Benefit:** 75% = $1,451.40 |
| 37212 | PROSTATE, open perineal biopsy or open drainage of abscess (Anaes.) (Assist.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 |
| 37215 | PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.)<br>**Fee:** $416.45 **Benefit:** 75% = $312.35 85% = $354.00 |
| 37217 | Prostate, implantation of gold fiducial markers into the prostate gland or prostate surgical bed (Anaes.)<br>*(See para T8.54 of explanatory notes to this Category)*<br>**Fee:** $138.30 **Benefit:** 75% = $103.75 85% = $117.60 |
| 37218 | PROSTATE, needle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.)<br>**Fee:** $138.30 **Benefit:** 75% = $103.75 85% = $117.60 |
| 37219 | PROSTATE, needle biopsy of, using prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) (Assist.)<br>**Fee:** $280.85 **Benefit:** 75% = $210.65 85% = $238.75 |
| 37220 | PROSTATE, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. (Anaes.)<br>*(See para T8.55 of explanatory notes to this Category)*<br>**Fee:** $1,044.20 **Benefit:** 75% = $783.15 |
| 37221 | PROSTATIC ABSCESS, endoscopic drainage of (Anaes.) (Assist.)<br>**Fee:** $466.35 **Benefit:** 75% = $349.80 |

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| 37223 | PROSTATIC COIL, insertion of, under ultrasound control (Anaes.)<br>**Fee:** $206.25 **Benefit:** 75% = $154.70 |
| 37224 | PROSTATE, diathermy or visual laser destruction of lesion of, not being a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.)<br>**Fee:** $323.20 **Benefit:** 75% = $242.40 85% = $274.75 |
| 37227 | PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15331 or 15332 applies. (Anaes.)<br>*(See para T8.56 of explanatory notes to this Category)*<br>**Fee:** $565.85 **Benefit:** 75% = $424.40 85% = $491.35 |
| 37230 | PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.)<br>**Fee:** $1,042.15 **Benefit:** 75% = $781.65 85% = $967.65 |
| 37233 | 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, 37230 which had to be discontinued for medical reasons (Anaes.)<br>**Fee:** $558.10 **Benefit:** 75% = $418.60 85% = $483.60 |
| **Amend** 37245 | **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.)<br>**Fee:** $1,262.15 **Benefit:** 75% = $946.65 |
| | *OPERATIONS ON URETHRA, PENIS OR SCROTUM* |
| 37300 | URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.)<br>**Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65 |
| 37303 | URETHRAL STRICTURE, dilatation of (Anaes.)<br>**Fee:** $74.05 **Benefit:** 75% = $55.55 85% = $62.95 |
| 37306 | URETHRA, repair of rupture of distal section (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 |
| 37309 | URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 37315 | URETHROSCOPY, as an independent procedure (Anaes.)<br>**Fee:** $138.30 **Benefit:** 75% = $103.75 85% = $117.60 |
| 37318 | URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 |
| 37321 | URETHRAL MEATOTOMY, EXTERNAL (Anaes.)<br>**Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35 |
| 37324 | URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.)<br>**Fee:** $229.85 **Benefit:** 75% = $172.40 |
| 37327 | URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.)<br>**Fee:** $323.20 **Benefit:** 75% = $242.40 |
| 37330 | URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.)<br>**Fee:** $649.80 **Benefit:** 75% = $487.35 |
| 37333 | URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.)<br>**Fee:** $558.10 **Benefit:** 75% = $418.60 |
| 37336 | URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |

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| 37339 | PERIURETHRAL OR TRANSURETHRAL INJECTION of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.)<br>**Fee:** $239.85 **Benefit:** 75% = $179.90 85% = $203.90 |
| 37340 | URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Anaes.) (Assist.)<br>**Fee:** $425.00 **Benefit:** 75% = $318.75 |
| 37341 | URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.) (Assist.)<br>**Fee:** $911.30 **Benefit:** 75% = $683.50 |
| 37342 | URETHROPLASTY single stage operation (Anaes.) (Assist.)<br>**Fee:** $833.10 **Benefit:** 75% = $624.85 |
| 37343 | URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.)<br>**Fee:** $1,391.15 **Benefit:** 75% = $1,043.40 |
| 37345 | URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 |
| 37348 | URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 |
| 37351 | URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 |
| 37354 | HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.)<br>**Fee:** $323.20 **Benefit:** 75% = $242.40 |
| 37369 | URETHRA, excision of prolapse of (Anaes.)<br>**Fee:** $186.60 **Benefit:** 75% = $139.95 |
| 37372 | URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.)<br>**Fee:** $466.35 **Benefit:** 75% = $349.80 |
| 37375 | URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.)<br>**Fee:** $1,157.85 **Benefit:** 75% = $868.40 |
| 37381 | ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 37384 | ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.)<br>**Fee:** $1,157.85 **Benefit:** 75% = $868.40 |
| 37387 | ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.)<br>**Fee:** $323.20 **Benefit:** 75% = $242.40 |
| 37390 | ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 37393 | PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.)<br>**Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40 |
| 37396 | PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 |
| 37402 | PENIS, partial amputation of (Anaes.) (Assist.)<br>**Fee:** $466.35 **Benefit:** 75% = $349.80 |
| 37405 | PENIS, complete or radical amputation of (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |

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| 37408 | PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)<br>**Fee:** $466.35 **Benefit:** 75% = $349.80 |
| 37411 | PENIS, repair of avulsion (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 85% = $850.20 |
| 37415 | PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months<br>**Fee:** $46.60 **Benefit:** 75% = $34.95 85% = $39.65 |
| 37417 | PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.)<br>**Fee:** $558.10 **Benefit:** 75% = $418.60 |
| 37418 | PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Anaes.) (Assist.)<br>**Fee:** $741.50 **Benefit:** 75% = $556.15 85% = $667.00 |
| 37420 | 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.)<br>**Fee:** $366.45 **Benefit:** 75% = $274.85 |
| 37423 | PENIS, lengthening by translocation of corpora (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 37426 | PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.)<br>**Fee:** $974.55 **Benefit:** 75% = $730.95 |
| 37429 | PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.)<br>**Fee:** $323.20 **Benefit:** 75% = $242.40 |
| 37432 | PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |
| 37435 | PENIS, frenuloplasty as an independent procedure (Anaes.)<br>**Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35 |
| 37438 | SCROTUM, partial excision of (Anaes.) (Assist.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 |
| 37444 | URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.)<br>**Fee:** $999.65 **Benefit:** 75% = $749.75 85% = $925.15 |
| | *OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES* |
| 37601 | SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 |
| 37604 | EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 |
| 37605 | TRANSCUTANEOUS SPERM RETRIEVAL, unilateral, from either the testis or the epididymis, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, excluding a service to which item 13218 applies. (Anaes.)<br>*(See para T8.58 of explanatory notes to this Category)*<br>**Fee:** $373.45 **Benefit:** 75% = $280.10 85% = $317.45 |
| 37606 | OPEN SURGICAL SPERM RETRIEVAL, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.)<br>*(See para T8.59 of explanatory notes to this Category)*<br>**Fee:** $554.55 **Benefit:** 75% = $415.95 85% = $480.05 |
| 37607 | RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.)<br>**Fee:** $924.70 **Benefit:** 75% = $693.55 |

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| 37610 | RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes.) (Assist.)<br>**Fee:** $1,391.15 **Benefit:** 75% = $1,043.40 |
| 37613 | EPIDIDYMECTOMY (Anaes.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15 |
| 37616 | VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 |
| 37619 | VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.)<br>**Fee:** $276.60 **Benefit:** 75% = $207.45 85% = $235.15<br>**Extended Medicare Safety Net Cap:** $221.30 |
| 37622 G<br>37623 S | VASOTOMY OR VASECTOMY, unilateral or bilateral<br><br>**NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.)<br>*(See para T8.46 of explanatory notes to this Category)*<br>**Fee:** $193.20 **Benefit:** 75% = $144.90 85% = $164.25<br>**Fee:** $229.85 **Benefit:** 75% = $172.40 85% = $195.40 |
| | *PAEDIATRIC GENITURINARY SURGERY* |
| 37800 | PATENT URACHUS, excision of (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 37803 | UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 37806 | UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.) (Assist.)<br>**Fee:** $602.25 **Benefit:** 75% = $451.70 85% = $527.75 |
| 37809 | UNDESCENDED TESTIS, revision orchidopexy for (Anaes.) (Assist.)<br>**Fee:** $602.25 **Benefit:** 75% = $451.70 |
| 37812 | IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 applies (Anaes.) (Assist.)<br>**Fee:** $556.00 **Benefit:** 75% = $417.00 |
| 37815 | HYPOSPADIAS, examination under anaesthesia with erection test (Anaes.)<br>**Fee:** $92.75 **Benefit:** 75% = $69.60 |
| 37818 | HYPOSPADIAS, glanuloplasty incorporating meatal advancement (Anaes.) (Assist.)<br>**Fee:** $491.45 **Benefit:** 75% = $368.60 85% = $417.75 |
| 37821 | HYPOSPADIAS, distal, 1 stage repair (Anaes.) (Assist.)<br>**Fee:** $833.10 **Benefit:** 75% = $624.85 |
| 37824 | HYPOSPADIAS, proximal, 1 stage repair (Anaes.) (Assist.)<br>**Fee:** $1,158.30 **Benefit:** 75% = $868.75 |
| 37827 | HYPOSPADIAS, staged repair, first stage (Anaes.) (Assist.)<br>**Fee:** $533.60 **Benefit:** 75% = $400.20 |
| 37830 | HYPOSPADIAS, staged repair, second stage (Anaes.) (Assist.)<br>**Fee:** $691.40 **Benefit:** 75% = $518.55 85% = $616.90 |
| 37833 | HYPOSPADIAS, repair of post operative urethral fistula (Anaes.) (Assist.)<br>**Fee:** $329.95 **Benefit:** 75% = $247.50 |
| 37836 | EPISPADIAS, staged repair, first stage (Anaes.) (Assist.)<br>**Fee:** $695.00 **Benefit:** 75% = $521.25 |

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| 37839 | EPISPADIAS, staged repair, second stage (Anaes.) (Assist.)<br>**Fee:** $787.60 **Benefit:** 75% = $590.70 |
| 37842 | EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.)<br>**Fee:** $1,529.10 **Benefit:** 75% = $1,146.85 |
| 37845 | AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.)<br>**Fee:** $695.00 **Benefit:** 75% = $521.25 |
| 37848 | AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.)<br>**Fee:** $1,251.05 **Benefit:** 75% = $938.30 |
| 37851 | CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.)<br>**Fee:** $926.80 **Benefit:** 75% = $695.10 |
| 37854 | URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.)<br>**Fee:** $366.45 **Benefit:** 75% = $274.85 |
| | *SUBGROUP 6 - CARDIO-THORACIC* |
| | *CARDIOLOGY PROCEDURES* |
| 38200 | RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.)<br>**Fee:** $445.40 **Benefit:** 75% = $334.05 85% = $378.60 |
| 38203 | 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.)<br>**Fee:** $531.55 **Benefit:** 75% = $398.70 85% = $457.05 |
| 38206 | RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure 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.)<br>**Fee:** $642.65 **Benefit:** 75% = $482.00 85% = $568.15 |
| 38209 | CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.)<br>*(See para T8.60 of explanatory notes to this Category)*<br>**Fee:** $825.15 **Benefit:** 75% = $618.90 85% = $750.65 |
| 38212 | CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.)<br>*(See para T8.60 of explanatory notes to this Category)*<br>**Fee:** $1,372.45 **Benefit:** 75% = $1,029.35 85% = $1,297.95 |
| 38213 | CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.)<br>**Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40 |
| 38215 | SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $354.90 **Benefit:** 75% = $266.20 85% = $301.70 |

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| 38218 | SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $532.25 | **Benefit:** 75% = $399.20 | 85% = $457.75 |
| 38220 | SELECTIVE CORONARY GRAFT ANGIOGRAPHY 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, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $177.40 | **Benefit:** 75% = $133.05 | 85% = $150.80 |
| 38222 | SELECTIVE CORONARY GRAFT ANGIOGRAPHY, 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, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $354.90 | **Benefit:** 75% = $266.20 | 85% = $301.70 |
| 38225 | 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 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, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $532.35 | **Benefit:** 75% = $399.30 | 85% = $457.85 |
| 38228 | 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 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, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $709.90 | **Benefit:** 75% = $532.45 | 85% = $635.40 |
| 38231 | 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.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $887.25 | **Benefit:** 75% = $665.45 | 85% = $812.75 |
| 38234 | 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.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $709.75 | **Benefit:** 75% = $532.35 | 85% = $635.25 |
| 38237 | 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.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $887.20 | **Benefit:** 75% = $665.40 | 85% = $812.70 |
| 38240 | 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.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $1,064.60 | **Benefit:** 75% = $798.45 | 85% = $990.10 |

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| 38241 | 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 inconlclusive (Anaes.)<br>**Fee:** $469.70 **Benefit:** 75% = $352.30 85% = $399.25 |
| 38243 | 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.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $443.60 **Benefit:** 75% = $332.70 85% = $377.10 |
| 38246 | 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.)<br>*(See para T8.52 of explanatory notes to this Category)*<br>**Fee:** $887.20 **Benefit:** 75% = $665.40 85% = $812.70 |
| 38256 | TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.)<br>**Fee:** $267.25 **Benefit:** 75% = $200.45 85% = $227.20 |
| 38270 | BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.)<br>**Fee:** $912.30 **Benefit:** 75% = $684.25 85% = $837.80 |
| 38272 | ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.)<br>**Fee:** $912.30 **Benefit:** 75% = $684.25 85% = $837.80 |
| 38275 | MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.)<br>**Fee:** $298.20 **Benefit:** 75% = $223.65 85% = $253.50 |
| 38285 | IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where:<br>- a diagnosis has not been achieved through all other available cardiac investigations; and<br>- a neurogenic cause is not suspected; and<br>- it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death.<br>including initial programming and testing, as an admitted patient in an approved hospital (Anaes.)<br>*(See para T8.61 of explanatory notes to this Category)*<br>**Fee:** $192.90 **Benefit:** 75% = $144.70 85% = $164.00 |
| 38286 | IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.)<br>**Fee:** $173.75 **Benefit:** 75% = $130.35 85% = $147.70 |
| | *CATHETER BASED ARRHYTHMIA ABLATION* |
| 38287 | ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.)<br>**Fee:** $2,098.45 **Benefit:** 75% = $1,573.85 85% = $2,023.95 |
| 38290 | ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)<br>**Fee:** $2,671.95 **Benefit:** 75% = $2,004.00 |
| 38293 | VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)<br>**Fee:** $2,868.05 **Benefit:** 75% = $2,151.05 85% = $2,793.55 |
| | *ENDOVASCULAR INTERVENTIONAL PROCEDURES* |
| 38300 | TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $515.35 **Benefit:** 75% = $386.55 85% = $440.85 |
| 38303 | TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $660.80 **Benefit:** 75% = $495.60 85% = $586.30 |

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| 38306 | TRANSLUMINAL INSERTION OF STENT OR STENTS into 1 occlusional site, including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.62 of explanatory notes to this Category)*<br>**Fee:** $762.35 **Benefit:** 75% = $571.80 85% = $687.85 |
| 38309 | PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where:<br>- no lesion of the coronary artery has been stented; and<br>- each lesion of the coronary artery is complex and heavily calcified; and<br>- balloon angioplasty with or without stenting is not suitable;<br>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.41 of explanatory notes to this Category)*<br>**Fee:** $885.45 **Benefit:** 75% = $664.10 85% = $810.95 |
| 38312 | PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where:<br>- no lesion of the coronary artery has been stented; and<br>- each lesion of the coronary artery is complex and heavily calcified; and<br>- balloon angioplasty with or without stenting is not suitable;<br>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.41 of explanatory notes to this Category)*<br>**Fee:** $1,132.35 **Benefit:** 75% = $849.30 85% = $1,057.85 |
| 38315 | PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where:<br>- no lesion of the coronary arteries has been stented; and<br>- each lesion of the coronary arteries is complex and heavily calcified; and<br>- balloon angioplasty with or without stenting is not suitable;<br>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.41 of explanatory notes to this Category)*<br>**Fee:** $1,215.85 **Benefit:** 75% = $911.90 85% = $1,141.35 |
| 38318 | PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where:<br>- no lesion of the coronary arteries has been stented; and<br>- each lesion of the coronary arteries is complex and heavily calcified; and<br>- balloon angioplasty with or without stenting is not suitable,<br>excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.41 of explanatory notes to this Category)*<br>**Fee:** $1,586.35 **Benefit:** 75% = $1,189.80 85% = $1,511.85 |
| | *MISCELLANEOUS CARDIAC PROCEDURES* |
| 38350 | SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)<br>*(See para T8.60 of explanatory notes to this Category)*<br>**Fee:** $638.65 **Benefit:** 75% = $479.00 |
| 38353 | PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)<br>*(See para T8.60 of explanatory notes to this Category)*<br>**Fee:** $255.45 **Benefit:** 75% = $191.60 |
| 38356 | DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)<br>*(See para T8.60 of explanatory notes to this Category)*<br>**Fee:** $837.35 **Benefit:** 75% = $628.05 |
| 38358 | 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.)<br>*(See para T8.64 of explanatory notes to this Category)*<br>**Fee:** $2,868.05 **Benefit:** 75% = $2,151.05 |
| 38359 | PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.)<br>**Fee:** $133.55 **Benefit:** 75% = $100.20 85% = $113.55 |

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| 38362 | INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.)<br>**Fee:** $384.95 **Benefit:** 75% = $288.75 85% = $327.25 |
| 38365 | PERMANENT CARDIAC SYNCRONISATION DEVICE, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria:<br>- sinus rhythm<br>- a left ventricular ejection fraction of less than or equal to 35%<br>- a QRS duration greater than or equal to 120ms. (Anaes.)<br>*(See para T8.63 of explanatory notes to this Category)*<br>**Fee:** $255.45 **Benefit:** 75% = $191.60 |
| 38368 | PERMANENT TRANSVENOUS LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria:<br>- sinus rhythm<br>- a left ventricular ejection fraction of less than or equal to 35%<br>- a QRS duration greater than or equal to 120ms.<br>Where the service includes right heart catheterisation and any associated venogram of left ventricular veins. Not being a service associated with a service to which items 38200 and 35200 apply (Anaes.)<br>*(See para T8.63 of explanatory notes to this Category)*<br>**Fee:** $1,224.60 **Benefit:** 75% = $918.45 |
| 38371 | PERMANENT CARDIAC SYNCHRONISATION DEVICE CAPABLE OF DEFIBRILLATION, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy who meet all of the following criteria:<br>- sinus rhythm<br>- a left ventricular ejection fraction of less than or equal to 35%<br>- a QRS duration greater than or equal to 120ms. (Anaes.)<br>*(See para T8.65 of explanatory notes to this Category)*<br>**Fee:** $287.85 **Benefit:** 75% = $215.90 85% = $244.70 |
| 38384 | AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in:<br>- 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<br>- 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.<br>Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.)<br>**Fee:** $1,052.65 **Benefit:** 75% = $789.50 85% = $978.15 |
| 38387 | AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in:<br>- 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<br>- 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.<br>Not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.)<br>**Fee:** $287.85 **Benefit:** 75% = $215.90 85% = $244.70 |
| 38390 | AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.)<br>**Fee:** $1,052.65 **Benefit:** 75% = $789.50 85% = $978.15 |
| 38393 | AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Anaes.) (Assist.)<br>**Fee:** $287.85 **Benefit:** 75% = $215.90 85% = $244.70 |

| | *THORACIC SURGERY* |
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| 38415 | EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.)<br>**Fee:** $399.35 **Benefit:** 75% = $299.55 85% = $339.45 |
| 38418 | THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.)<br>**Fee:** $958.40 **Benefit:** 75% = $718.80 |
| 38421 | THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.)<br>**Fee:** $1,532.00 **Benefit:** 75% = $1,149.00 |
| 38424 | THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.)<br>**Fee:** $958.40 **Benefit:** 75% = $718.80 |
| 38427 | THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.)<br>**Fee:** $1,183.40 **Benefit:** 75% = $887.55 |
| 38430 | THORACOPLASTY (in stages) each stage (Anaes.) (Assist.)<br>**Fee:** $609.90 **Benefit:** 75% = $457.45 |
| 38436 | THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.)<br>**Fee:** $249.75 **Benefit:** 75% = $187.35 |
| 38438 | PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.)<br>**Fee:** $1,532.00 **Benefit:** 75% = $1,149.00 |
| 38440 | LUNG, wedge resection of (Anaes.) (Assist.)<br>**Fee:** $1,147.20 **Benefit:** 75% = $860.40 |
| 38441 | RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.)<br>**Fee:** $1,815.20 **Benefit:** 75% = $1,361.40 |
| 38446 | THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.)<br>**Fee:** $1,183.40 **Benefit:** 75% = $887.55 |
| 38447 | PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.)<br>**Fee:** $1,532.00 **Benefit:** 75% = $1,149.00 |
| 38448 | MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.)<br>**Fee:** $363.05 **Benefit:** 75% = $272.30 |
| 38449 | PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.)<br>**Fee:** $2,143.20 **Benefit:** 75% = $1,607.40 |
| 38450 | PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.)<br>**Fee:** $856.65 **Benefit:** 75% = $642.50 |
| 38452 | PERICARDIUM, sub-xyphoid drainage of (Anaes.) (Assist.)<br>**Fee:** $573.70 **Benefit:** 75% = $430.30 |
| 38453 | TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.)<br>**Fee:** $1,720.90 **Benefit:** 75% = $1,290.70 |
| 38455 | TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.)<br>**Fee:** $2,327.70 **Benefit:** 75% = $1,745.80 |
| 38456 | INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $1,532.00 **Benefit:** 75% = $1,149.00 |
| 38457 | PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.)<br>**Fee:** $1,430.25 **Benefit:** 75% = $1,072.70 |

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| 38458 | PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.)<br>**Fee:** $762.35 **Benefit:** 75% = $571.80 |
| 38460 | STERNAL WIRE OR WIRES, removal of (Anaes.)<br>**Fee:** $275.40 **Benefit:** 75% = $206.55 |
| 38462 | STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.)<br>**Fee:** $326.45 **Benefit:** 75% = $244.85 |
| 38464 | STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.)<br>**Fee:** $354.80 **Benefit:** 75% = $266.10 |
| 38466 | STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.)<br>**Fee:** $958.00 **Benefit:** 75% = $718.50 |
| 38468 | STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.)<br>**Fee:** $1,476.15 **Benefit:** 75% = $1,107.15 |
| 38469 | STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.)<br>**Fee:** $1,720.90 **Benefit:** 75% = $1,290.70 |
| | *CARDIAC SURGERY PROCEDURES* |
| 38470 | PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $958.40 **Benefit:** 75% = $718.80 |
| 38473 | PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $573.70 **Benefit:** 75% = $430.30 |
| | *VALVULAR PROCEDURES* |
| 38475 | VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $831.75 **Benefit:** 75% = $623.85 |
| 38477 | VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,003.35 **Benefit:** 75% = $1,502.55 |
| 38478 | VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $970.40 **Benefit:** 75% = $727.80 |
| 38480 | VALVE REPAIR, 1 leaflet (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,003.35 **Benefit:** 75% = $1,502.55 |
| 38481 | VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,280.65 **Benefit:** 75% = $1,710.50 |
| 38483 | AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,720.90 **Benefit:** 75% = $1,290.70 |
| 38485 | MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $817.10 **Benefit:** 75% = $612.85 |

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| 38487 | MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,720.90 **Benefit:** 75% = $1,290.70 |
| 38488 | VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,909.60 **Benefit:** 75% = $1,432.20 |
| 38489 | VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,271.05 **Benefit:** 75% = $1,703.30 |
| 38490 | SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $554.55 **Benefit:** 75% = $415.95 |
| 38493 | OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,957.60 **Benefit:** 75% = $1,468.20 |
| | *SURGERY FOR ISCHAEMIC HEART DISEASE* |
| 38496 | ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $623.95 **Benefit:** 75% = $468.00 |
| 38497 | 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 asociated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.)<br>*(See para T8.67 and T8.68 of explanatory notes to this Category)*<br>**Fee:** $2,047.60 **Benefit:** 75% = $1,535.70 |
| 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, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.)<br>*(See para T8.67 and T8.68 of explanatory notes to this Category)*<br>**Fee:** $2,047.60 **Benefit:** 75% = $1,535.70 |
| 38500 | CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.)<br>*(See para T8.67 and T8.68 of explanatory notes to this Category)*<br>**Fee:** $2,200.00 **Benefit:** 75% = $1,650.00 |
| 38501 | CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or 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, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.)<br>*(See para T8.67 and T8.68 of explanatory notes to this Category)*<br>**Fee:** $2,200.00 **Benefit:** 75% = $1,650.00 |
| 38503 | CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.)<br>*(See para T8.67 and T8.68 of explanatory notes to this Category)*<br>**Fee:** $2,388.70 **Benefit:** 75% = $1,791.55 |
| 38504 | CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or 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, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.)<br>*(See para T8.67 and T8.68 of explanatory notes to this Category)*<br>**Fee:** $2,388.70 **Benefit:** 75% = $1,791.55 |

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| 38505 | CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $277.25 **Benefit:** 75% = $207.95 |
| 38506 | LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,626.25 **Benefit:** 75% = $1,219.70 |
| 38507 | LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,909.20 **Benefit:** 75% = $1,431.90 |
| 38508 | LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,388.70 **Benefit:** 75% = $1,791.55 |
| 38509 | ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,388.70 **Benefit:** 75% = $1,791.55 |
| | *ARRHYTHMIA SURGERY* |
| 38512 | DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,098.45 **Benefit:** 75% = $1,573.85 |
| 38515 | 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.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,671.95 **Benefit:** 75% = $2,004.00 |
| 38518 | VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,868.05 **Benefit:** 75% = $2,151.05 |
| | *PROCEDURES ON THORACIC AORTA* |
| 38550 | ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,146.15 **Benefit:** 75% = $1,609.65 |
| 38553 | ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,719.75 **Benefit:** 75% = $2,039.85 |
| 38556 | ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $3,104.70 **Benefit:** 75% = $2,328.55 |
| 38559 | AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,531.00 **Benefit:** 75% = $1,898.25 |
| 38562 | AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $3,104.70 **Benefit:** 75% = $2,328.55 |

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| 38565 | AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $3,482.25 **Benefit:** 75% = $2,611.70 |
| 38568 | DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endvascular means (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,862.95 **Benefit:** 75% = $1,397.25 |
| 38571 | DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,051.75 **Benefit:** 75% = $1,538.85 |
| 38572 | OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,987.05 **Benefit:** 75% = $1,490.30 |
| 38577 | CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $554.55 **Benefit:** 75% = $415.95 |
| | *TECHNIQUES FOR PRESERVATION OF ARRESTED HEART* |
| 38588 | CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $416.05 **Benefit:** 75% = $312.05 |
| | *CIRCULATORY SUPPORT PROCEDURES* |
| 38600 | CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,532.00 **Benefit:** 75% = $1,149.00 |
| 38603 | PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $958.40 **Benefit:** 75% = $718.80 |
| 38609 | INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $479.15 **Benefit:** 75% = $359.40 |
| 38612 | INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $537.10 **Benefit:** 75% = $402.85 85% = $462.60 |
| 38613 | INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $674.05 **Benefit:** 75% = $505.55 |
| 38615 | LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,532.00 **Benefit:** 75% = $1,149.00 |
| 38618 | LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,909.60 **Benefit:** 75% = $1,432.20 |
| 38621 | LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $762.35 **Benefit:** 75% = $571.80 |

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| 38624 | LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $856.65 **Benefit:** 75% = $642.50 |
| 38627 | 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.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $669.60 **Benefit:** 75% = $502.20 |
| | *RE-OPERATION* |
| 38637 | PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $554.55 **Benefit:** 75% = $415.95 |
| 38640 | 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.)<br>*(See para T8.67 and T8.69 of explanatory notes to this Category)*<br>**Fee:** $958.40 **Benefit:** 75% = $718.80 |
| | *MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES* |
| 38643 | THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,067.40 **Benefit:** 75% = $800.55 |
| 38647 | THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38650 | MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,909.60 **Benefit:** 75% = $1,432.20 |
| 38653 | OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,909.60 **Benefit:** 75% = $1,432.20 |
| 38654 | PERMANENT LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria:<br>- sinus rhythm<br>- a left ventricular ejection fraction of less than or equal to 35%<br>- a QRS duration greater than or equal to 120ms. (Anaes.) (Assist.)<br>*(See para T8.63 and T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,224.60 **Benefit:** 75% = $918.45 |
| 38656 | THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $958.40 **Benefit:** 75% = $718.80 |
| | *CARDIAC TUMOURS* |
| 38670 | CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,909.20 **Benefit:** 75% = $1,431.90 |
| 38673 | CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,148.85 **Benefit:** 75% = $1,611.65 |

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| 38677 | CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,010.35 **Benefit:** 75% = $1,507.80 |
| 38680 | CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.)<br>**Fee:** $2,384.55 **Benefit:** 75% = $1,788.45 85% = $2,310.05 |
| | *CONGENITAL CARDIAC SURGERY* |
| 38700 | PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,067.40 **Benefit:** 75% = $800.55 |
| 38703 | PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,924.10 **Benefit:** 75% = $1,443.10 |
| 38706 | AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,822.40 **Benefit:** 75% = $1,366.80 |
| 38709 | AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38712 | AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,563.15 **Benefit:** 75% = $1,922.40 |
| 38715 | MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,706.30 **Benefit:** 75% = $1,279.75 |
| 38718 | MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38721 | VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,495.80 **Benefit:** 75% = $1,121.85 |
| 38724 | VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38727 | INTRATHORACIC VESSELS, anastomosis or repair of, without 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.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,495.80 **Benefit:** 75% = $1,121.85 |
| 38730 | 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.)<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38733 | SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,495.80 **Benefit:** 75% = $1,121.85 |

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| 38736 | SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38739 | ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,924.10 **Benefit:** 75% = $1,443.10 |
| 38742 | ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $1,924.10 **Benefit:** 75% = $1,443.10 |
| 38745 | INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38748 | VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38751 | VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38754 | INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,671.95 **Benefit:** 75% = $2,004.00 |
| 38757 | EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38760 | EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38763 | VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| 38766 | VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.)<br>*(See para T8.67 of explanatory notes to this Category)*<br>**Fee:** $2,134.50 **Benefit:** 75% = $1,600.90 |
| | *MISCELLANEOUS PROCEDURES ON THE CHEST* |
| 38800 | THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies<br>**Fee:** $38.50 **Benefit:** 75% = $28.90 85% = $32.75 |
| 38803 | THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample<br>**Fee:** $76.90 **Benefit:** 75% = $57.70 85% = $65.40 |
| 38806 | INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.)<br>**Fee:** $133.55 **Benefit:** 75% = $100.20 85% = $113.55 |
| 38809 | INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.)<br>**Fee:** $164.55 **Benefit:** 75% = $123.45 85% = $139.90 |
| 38812 | PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.)<br>**Fee:** $209.15 **Benefit:** 75% = $156.90 85% = $177.80 |

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| | *SUBGROUP 7 - NEUROSURGICAL* |
| | *GENERAL* |
| 39000 | LUMBAR PUNCTURE (Anaes.)<br>**Fee:** $75.30 **Benefit:** 75% = $56.50 85% = $64.05 |
| 39003 | CISTERNAL PUNCTURE (Anaes.)<br>**Fee:** $85.65 **Benefit:** 75% = $64.25 85% = $72.85 |
| 39006 | VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.)<br>**Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50 |
| 39009 | SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.)<br>**Fee:** $59.35 **Benefit:** 75% = $44.55 |
| 39012 | BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.)<br>**Fee:** $237.60 **Benefit:** 75% = $178.20 |
| 39013 | INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.)<br>**Fee:** $109.15 **Benefit:** 75% = $81.90 85% = $92.80 |
| 39015 | VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.)<br>**Fee:** $376.00 **Benefit:** 75% = $282.00 |
| 39018 | CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.)<br>**Fee:** $376.00 **Benefit:** 75% = $282.00 |
| | *PAIN RELIEF* |
| 39100 | INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)<br>**Fee:** $237.60 **Benefit:** 75% = $178.20 85% = $202.00 |
| 39106 | NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |
| 39109 | TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.)<br>**Fee:** $443.70 **Benefit:** 75% = $332.80 85% = $377.15 |
| 39112 | CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $1,541.50 **Benefit:** 75% = $1,156.15 |
| 39115 | 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.)<br>**Fee:** $75.30 **Benefit:** 75% = $56.50 85% = $64.05 |
| 39118 | PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.)<br>**Fee:** $297.85 **Benefit:** 75% = $223.40 85% = $253.20 |
| 39121 | PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $557.25 |
| 39124 | CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.)<br>**Fee:** $1,616.80 **Benefit:** 75% = $1,212.60 |
| 39125 | 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.)<br>**Fee:** $298.05 **Benefit:** 75% = $223.55 |

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| 39126 | 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.)<br>**Fee:** $361.90 **Benefit:** 75% = $271.45 |
| 39127 | SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.)<br>**Fee:** $473.65 **Benefit:** 75% = $355.25 |
| 39128 | INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion of, and connection of pump to 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.)<br>**Fee:** $659.95 **Benefit:** 75% = $495.00 |
| 39130 | EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.)<br>**Fee:** $674.15 **Benefit:** 75% = $505.65 |
| 39131 | ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day<br>**Fee:** $127.80 **Benefit:** 75% = $95.85 85% = $108.65 |
| 39133 | Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of chronic intractable pain (Anaes.)<br>**Fee:** $159.40 **Benefit:** 75% = $119.55 |
| 39134 | 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.)<br>**Fee:** $340.60 **Benefit:** 75% = $255.45 |
| 39135 | NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.)<br>**Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50 |
| 39136 | LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.)<br>**Fee:** $159.40 **Benefit:** 75% = $119.55 |
| 39137 | LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.)<br>**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 maximum of 4 leads (Anaes.) (Assist.)<br>**Fee:** $674.15 **Benefit:** 75% = $505.65 |
| 39139 | EPIDURAL LEAD, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.)<br>**Fee:** $905.10 **Benefit:** 75% = $678.85 |
| 39140 | EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.)<br>**Fee:** $292.85 **Benefit:** 75% = $219.65 85% = $248.95 |
| | *PERIPHERAL NERVES* |
| 39300 | CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 |
| 39303 | CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $466.10 **Benefit:** 75% = $349.60 |
| 39306 | NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $676.80 **Benefit:** 75% = $507.60 |

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| 39309 | NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $714.35 **Benefit:** 75% = $535.80 |
| 39312 | NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $398.55 **Benefit:** 75% = $298.95 |
| 39315 | NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $1,030.20 **Benefit:** 75% = $772.65 |
| 39318 | CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $639.20 **Benefit:** 75% = $479.40 |
| 39321 | NERVE, transposition of (Anaes.) (Assist.)<br>**Fee:** $473.65 **Benefit:** 75% = $355.25 |
| 39323 | PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30 |
| 39324 | NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30 |
| 39327 | NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.)<br>**Fee:** $473.75 **Benefit:** 75% = $355.35 |
| 39330 | NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 |
| 39331 | CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30 |
| 39333 | BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80 |
| | *CRANIAL NERVES* |
| 39500 | VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.)<br>**Fee:** $1,270.90 **Benefit:** 75% = $953.20 |
| 39503 | FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| | *CRANIO-CEREBRAL INJURIES* |
| 39600 | INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.)<br>**Fee:** $473.65 **Benefit:** 75% = $355.25 |
| 39603 | INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.)<br>**Fee:** $1,195.70 **Benefit:** 75% = $896.80 |
| 39606 | FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.)<br>**Fee:** $797.10 **Benefit:** 75% = $597.85 |
| 39609 | FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| 39612 | FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.)<br>**Fee:** $1,120.45 **Benefit:** 75% = $840.35 |
| 39615 | FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes.) (Assist.)<br>**Fee:** $1,195.70 **Benefit:** 75% = $896.80 |

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| | *SKULL BASE SURGERY* |
| 39640 | TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $3,031.65 **Benefit:** 75% = $2,273.75 |
| 39642 | TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $3,187.25 **Benefit:** 75% = $2,390.45 |
| 39646 | 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.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $3,653.60 **Benefit:** 75% = $2,740.20 |
| 39650 | 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.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $2,642.95 **Benefit:** 75% = $1,982.25 |
| 39653 | 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.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $4,703.15 **Benefit:** 75% = $3,527.40 |
| 39654 | 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.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $3,420.50 **Benefit:** 75% = $2,565.40 |
| 39656 | 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.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $2,565.30 **Benefit:** 75% = $1,924.00 |
| 39658 | TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $3,031.65 **Benefit:** 75% = $2,273.75 |
| 39660 | TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $3,031.65 **Benefit:** 75% = $2,273.75 |
| 39662 | TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.)<br>*(See para T8.70 of explanatory notes to this Category)*<br>**Fee:** $3,031.65 **Benefit:** 75% = $2,273.75 |
| | *INTRA-CRANIAL NEOPLASMS* |
| 39700 | SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.)<br>**Fee:** $556.60 **Benefit:** 75% = $417.45 |
| 39703 | INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.)<br>**Fee:** $519.00 **Benefit:** 75% = $389.25 |
| 39706 | INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.)<br>**Fee:** $1,112.85 **Benefit:** 75% = $834.65 |

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| 39709 | CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 39712 | CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.)<br>**Fee:** $2,865.00 **Benefit:** 75% = $2,148.75 |
| 39715 | PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.)<br>**Fee:** $1,985.30 **Benefit:** 75% = $1,489.00 |
| 39718 | ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.)<br>**Fee:** $872.30 **Benefit:** 75% = $654.25 |
| 39721 | CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.)<br>**Fee:** $797.10 **Benefit:** 75% = $597.85 |
| | *CEREBROVASCULAR DISEASE* |
| 39800 | ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.)<br>**Fee:** $2,857.55 **Benefit:** 75% = $2,143.20 |
| 39803 | INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.)<br>**Fee:** $2,857.55 **Benefit:** 75% = $2,143.20 |
| 39806 | ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.)<br>**Fee:** $1,285.75 **Benefit:** 75% = $964.35 |
| 39812 | INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 |
| 39815 | CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.)<br>**Fee:** $1,827.25 **Benefit:** 75% = $1,370.45 85% = $1,752.75 |
| 39818 | EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.)<br>**Fee:** $1,827.25 **Benefit:** 75% = $1,370.45 |
| 39821 | EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.)<br>**Fee:** $2,169.75 **Benefit:** 75% = $1,627.35 |
| | *INFECTION* |
| 39900 | INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.)<br>**Fee:** $519.00 **Benefit:** 75% = $389.25 |
| 39903 | INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 39906 | OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.)<br>**Fee:** $797.10 **Benefit:** 75% = $597.85 |
| | *CEREBROSPINAL FLUID CIRCULATION DISORDERS* |
| 40000 | VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.)<br>**Fee:** $917.40 **Benefit:** 75% = $688.05 |
| 40003 | CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.)<br>**Fee:** $917.40 **Benefit:** 75% = $688.05 |
| 40006 | LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.)<br>**Fee:** $721.95 **Benefit:** 75% = $541.50 |
| 40009 | CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.)<br>**Fee:** $526.40 **Benefit:** 75% = $394.80 |
| 40012 | THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.)<br>**Fee:** $1,030.20 **Benefit:** 75% = $772.65 |

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| 40015 | SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.)<br>**Fee:** $638.65 **Benefit:** 75% = $479.00 |
| 40018 | LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.)<br>**Fee:** $159.40 **Benefit:** 75% = $119.55 85% = $135.50 |
| | *CONGENITAL DISORDERS* |
| 40100 | MENINGOCELE, excision and closure of (Anaes.) (Assist.)<br>**Fee:** $691.75 **Benefit:** 75% = $518.85 |
| 40103 | MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.)<br>**Fee:** $1,015.25 **Benefit:** 75% = $761.45 |
| 40106 | ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.)<br>**Fee:** $1,030.20 **Benefit:** 75% = $772.65 |
| 40109 | ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.)<br>**Fee:** $1,112.85 **Benefit:** 75% = $834.65 |
| 40112 | TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.)<br>**Fee:** $1,428.75 **Benefit:** 75% = $1,071.60 |
| 40115 | CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.)<br>**Fee:** $721.95 **Benefit:** 75% = $541.50 |
| 40118 | CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| | *SPINAL DISORDERS* |
| 40300 | INTERVERTEBRAL DISC OR DISCS, partial or total laminectomy for removal of (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| 40301 | INTERVERTEBRAL DISC OR DISCS, microsurgical partial or total discectomy of (Anaes.) (Assist.)<br>**Fee:** $958.00 **Benefit:** 75% = $718.50 |
| 40303 | RECURRENT DISC LESION OR SPINAL STENOSIS, or both, partial or total laminectomy for - 1 level (Anaes.) (Assist.)<br>**Fee:** $1,090.35 **Benefit:** 75% = $817.80 |
| 40306 | SPINAL STENOSIS, partial or total laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.) (Assist.)<br>**Fee:** $1,436.30 **Benefit:** 75% = $1,077.25 |
| 40309 | EEXTRADURAL TUMOUR OR ABSCESS, partial or total laminectomy for (Anaes.) (Assist.)<br>**Fee:** $1,090.35 **Benefit:** 75% = $817.80 |
| 40312 | INTRADURAL LESION, partial or total laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $1,466.30 **Benefit:** 75% = $1,099.75 |
| 40315 | CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 40316 | ODONTOID screw fixation (Anaes.) (Assist.)<br>**Fee:** $2,079.75 **Benefit:** 75% = $1,559.85 |
| 40318 | INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, partial or total laminectomy and radical excision of (Anaes.) (Assist.)<br>**Fee:** $1,985.30 **Benefit:** 75% = $1,489.00 |
| 40321 | POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.)<br>**Fee:** $1,090.35 **Benefit:** 75% = $817.80 |
| 40324 | PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – laminectomy, including aftercare (Anaes.) (Assist.)<br>**Fee:** $639.20 **Benefit:** 75% = $479.40 |

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| 40327 | PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – posterior fusion, including aftercare (Assist.)<br>**Fee:** $639.20 **Benefit:** 75% = $479.40 |
| 40330 | SPINAL RHIZOLYSIS involving exposure of spinal nerve roots – for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at 1 or more levels – with or without partial or total laminectomy (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| 40331 | CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| 40332 | CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Anaes.) (Assist.)<br>**Fee:** $1,558.30 **Benefit:** 75% = $1,168.75 |
| 40333 | CERVICAL PARTIAL OR TOTAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.)<br>**Fee:** $797.10 **Benefit:** 75% = $597.85 |
| 40334 | CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.)<br>**Fee:** $1,053.90 **Benefit:** 75% = $790.45 |
| 40335 | CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.)<br>**Fee:** $1,935.60 **Benefit:** 75% = $1,451.70 |
| 40336 | INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes.) (Assist.)<br>*(See para T8.71 of explanatory notes to this Category)*<br>**Fee:** $315.90 **Benefit:** 75% = $236.95 |
| 40339 | HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes.) (Assist.)<br>**Fee:** $1,586.75 **Benefit:** 75% = $1,190.10 |
| 40342 | HYDROMYELIA, craniotomy and partial or total laminectomy for, with cavity packing and CSF shunt (Anaes.) (Assist.)<br>**Fee:** $1,466.30 **Benefit:** 75% = $1,099.75 |
| 40345 | THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.) (Assist.)<br>**Fee:** $1,365.00 **Benefit:** 75% = $1,023.75 |
| 40348 | THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.)<br>**Fee:** $1,733.10 **Benefit:** 75% = $1,299.85 |
| 40351 | THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.) (Assist.)<br>**Fee:** $1,733.10 **Benefit:** 75% = $1,299.85 |
| | *SKULL RECONSTRUCTION* |
| 40600 | CRANIOPLASTY, reconstructive (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| | *EPILEPSY* |
| 40700 | CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.)<br>**Fee:** $1,744.65 **Benefit:** 75% = $1,308.50 |
| 40703 | CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.)<br>**Fee:** $1,466.30 **Benefit:** 75% = $1,099.75 |
| 40706 | HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.)<br>**Fee:** $2,143.10 **Benefit:** 75% = $1,607.35 85% = $2,068.60 |
| 40709 | BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.)<br>**Fee:** $519.00 **Benefit:** 75% = $389.25 |

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| 40712 | INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.)<br>**Fee:** $1,045.20 **Benefit:** 75% = $783.90 |
| | *STEREOTACTIC PROCEDURES* |
| 40800 | STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $638.65 **Benefit:** 75% = $479.00 85% = $564.15 |
| 40801 | 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.)<br>**Fee:** $1,745.80 **Benefit:** 75% = $1,309.35 |
| 40803 | INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.)<br>**Fee:** $1,195.70 **Benefit:** 75% = $896.80 85% = $1,121.20 |
| 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:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.)<br>**Fee:** $2,264.45 **Benefit:** 75% = $1,698.35 |
| 40851 | DEEP BRAIN STIMULATION (bilateral) 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:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)<br>**Fee:** $3,963.00 **Benefit:** 75% = $2,972.25 |
| 40852 | DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)<br>**Fee:** $340.60 **Benefit:** 75% = $255.45 |
| 40854 | DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the treatment of:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)<br>**Fee:** $526.40 **Benefit:** 75% = $394.80 |
| 40856 | DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)<br>**Fee:** $255.45 **Benefit:** 75% = $191.60 |
| 40858 | DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension lead for the treatment of:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)<br>**Fee:** $526.40 **Benefit:** 75% = $394.80 |

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| 40860 | 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:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)<br>**Fee:** $2,022.70 **Benefit:** 75% = $1,517.05 |
| 40862 | DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of:<br><br>Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or<br>Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.)<br>**Fee:** $189.70 **Benefit:** 75% = $142.30 85% = $161.25 |
| | *MISCELLANEOUS* |
| 40903 | NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.)<br>**Fee:** $554.55 **Benefit:** 75% = $415.95 |
| 40905 | CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.)<br>**Fee:** $601.70 **Benefit:** 75% = $451.30 85% = $527.20 |
| | *SUBGROUP 8 - EAR, NOSE AND THROAT* |
| 41500 | EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)<br>*(See para T8.72 of explanatory notes to this Category)*<br>**Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15 |
| 41503 | EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.)<br>**Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00 |
| 41506 | AURAL POLYP, removal of (Anaes.)<br>**Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40 |
| 41509 | EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.)<br>**Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55 |
| 41512 | MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.)<br>**Fee:** $585.90 **Benefit:** 75% = $439.45 |
| 41515 | MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.)<br>*(See para T8.73 of explanatory notes to this Category)*<br>**Fee:** $384.55 **Benefit:** 75% = $288.45 |
| 41518 | EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)<br>**Fee:** $928.75 **Benefit:** 75% = $696.60 |
| 41521 | Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.)<br>**Fee:** $988.85 **Benefit:** 75% = $741.65 |
| 41524 | RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.)<br>*(See para T8.74 of explanatory notes to this Category)*<br>**Fee:** $285.70 **Benefit:** 75% = $214.30 |
| 41527 | MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 |
| 41530 | MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.)<br>**Fee:** $957.30 **Benefit:** 75% = $718.00 |

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| 41533 | ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)<br>**Fee:** $1,144.30 **Benefit:** 75% = $858.25 |
| 41536 | ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)<br>**Fee:** $1,281.70 **Benefit:** 75% = $961.30 |
| 41539 | OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.)<br>**Fee:** $1,089.90 **Benefit:** 75% = $817.45 |
| 41542 | OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.)<br>**Fee:** $1,194.25 **Benefit:** 75% = $895.70 |
| 41545 | MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 41548 | OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.)<br>**Fee:** $691.75 **Benefit:** 75% = $518.85 |
| 41551 | MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.)<br>**Fee:** $1,593.05 **Benefit:** 75% = $1,194.80 |
| 41554 | MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.)<br>**Fee:** $1,876.95 **Benefit:** 75% = $1,407.75 |
| 41557 | MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.)<br>**Fee:** $1,089.90 **Benefit:** 75% = $817.45 |
| 41560 | MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.)<br>**Fee:** $1,194.25 **Benefit:** 75% = $895.70 |
| 41563 | MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.)<br>**Fee:** $1,478.40 **Benefit:** 75% = $1,108.80 |
| 41564 | MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.)<br>**Fee:** $1,911.80 **Benefit:** 75% = $1,433.85 |
| 41566 | REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.)<br>**Fee:** $1,089.90 **Benefit:** 75% = $817.45 |
| 41569 | DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.)<br>**Fee:** $1,194.25 **Benefit:** 75% = $895.70 |
| 41572 | LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.)<br>**Fee:** $1,033.20 **Benefit:** 75% = $774.90 |
| 41575 | CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.)<br>**Fee:** $2,435.70 **Benefit:** 75% = $1,826.80 |
| 41576 | CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.)<br>**Fee:** $3,653.60 **Benefit:** 75% = $2,740.20 |
| 41578 | CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.)<br>**Fee:** $2,435.70 **Benefit:** 75% = $1,826.80 |
| 41579 | CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.)<br>**Fee:** $1,826.75 **Benefit:** 75% = $1,370.10 |
| 41581 | TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.)<br>**Fee:** $2,801.55 **Benefit:** 75% = $2,101.20 |

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| 41584 | PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.)<br>**Fee:** $1,922.65 **Benefit:** 75% = $1,442.00 |
| 41587 | TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.)<br>**Fee:** $2,618.60 **Benefit:** 75% = $1,963.95 |
| 41590 | ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.)<br>**Fee:** $1,194.25 **Benefit:** 75% = $895.70 |
| 41593 | TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.)<br>**Fee:** $1,556.50 **Benefit:** 75% = $1,167.40 |
| 41596 | RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.)<br>**Fee:** $1,739.50 **Benefit:** 75% = $1,304.65 |
| 41599 | INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.)<br>**Fee:** $1,739.50 **Benefit:** 75% = $1,304.65 |
| 41603 | OSSEO-INTEGRATION PROCEDURE – implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients:<br>- With a permanent or long term hearing loss; and<br>- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and<br>- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.<br>Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)<br>**Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $429.35 |
| 41604 | OSSEO-INTEGRATION PROCEDURE – fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients:<br>- With a permanent or long term hearing loss; and<br>- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and<br>- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.<br>Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.)<br>**Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55 |
| 41608 | STAPEDECTOMY (Anaes.) (Assist.)<br>**Fee:** $1,089.90 **Benefit:** 75% = $817.45 |
| 41611 | STAPES MOBILISATION (Anaes.) (Assist.)<br>**Fee:** $701.30 **Benefit:** 75% = $526.00 |
| 41614 | ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.)<br>**Fee:** $1,089.90 **Benefit:** 75% = $817.45 85% = $1,015.40 |
| 41615 | OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $1,089.90 **Benefit:** 75% = $817.45 85% = $1,015.40 |
| 41617 | COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.)<br>**Fee:** $1,895.20 **Benefit:** 75% = $1,421.40 |
| 41620 | GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.)<br>**Fee:** $824.55 **Benefit:** 75% = $618.45 |
| 41623 | GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.)<br>**Fee:** $1,194.25 **Benefit:** 75% = $895.70 |
| 41626 | ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.)<br>**Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40 |
| 41629 | MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |

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| 41632 | MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.)<br>**Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00 |
| 41635 | CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.)<br>**Fee:** $1,144.30 **Benefit:** 75% = $858.25 85% = $1,069.80 |
| 41638 | CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.)<br>**Fee:** $1,428.35 **Benefit:** 75% = $1,071.30 |
| 41641 | PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.)<br>**Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35 |
| 41644 | EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.)<br>**Fee:** $142.80 **Benefit:** 75% = $107.10 85% = $121.40 |
| 41647 | EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.)<br>**Fee:** $109.90 **Benefit:** 75% = $82.45 85% = $93.45 |
| 41650 | TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $109.90 **Benefit:** 75% = $82.45 85% = $93.45 |
| 41653 | EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $71.95 **Benefit:** 75% = $54.00 85% = $61.20 |
| 41656 | NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.)<br>**Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45 |
| 41659 | NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.)<br>**Fee:** $77.55 **Benefit:** 75% = $58.20 85% = $65.95 |
| 41662 | NASAL POLYP OR POLYPI (SIMPLE), removal of<br>*(See para T8.75 of explanatory notes to this Category)*<br>**Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15 |
| 41665 G<br>41668 S | NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.)<br>*(See para T8.75 of explanatory notes to this Category)*<br>**Fee:** $172.50 **Benefit:** 75% = $129.40<br>**Fee:** $219.95 **Benefit:** 75% = $165.00 |
| 41671 | NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.)<br>**Fee:** $483.25 **Benefit:** 75% = $362.45 |
| 41672 | NASAL SEPTUM, reconstruction of (Anaes.) (Assist.)<br>**Fee:** $602.85 **Benefit:** 75% = $452.15 |
| 41674 | CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.)<br>**Fee:** $100.50 **Benefit:** 75% = $75.40 85% = $85.45 |
| 41677 | NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.)<br>**Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50 |
| 41680 | CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.)<br>**Fee:** $162.95 **Benefit:** 75% = $122.25 85% = $138.55 |
| 41683 | DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.)<br>**Fee:** $117.20 **Benefit:** 75% = $87.90 85% = $99.65 |

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| 41686 | DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $71.95 **Benefit:** 75% = $54.00 85% = $61.20 |
| 41689 | TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.)<br>**Fee:** $136.50 **Benefit:** 75% = $102.40 |
| 41692 | TURBINATES, submucous resection of, unilateral (Anaes.)<br>**Fee:** $178.05 **Benefit:** 75% = $133.55 |
| 41695 | TURBINATES, cryotherapy to (Anaes.)<br>**Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00 |
| 41698 | MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.)<br>**Fee:** $32.55 **Benefit:** 75% = $24.45 85% = $27.70 |
| 41701 | 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.)<br>**Fee:** $91.90 **Benefit:** 75% = $68.95 |
| 41704 | MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.)<br>**Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90 |
| 41707 | MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.)<br>**Fee:** $448.55 **Benefit:** 75% = $336.45 |
| 41710 | ANTROSTOMY (RADICAL) (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 41713 | ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.)<br>**Fee:** $606.50 **Benefit:** 75% = $454.90 |
| 41716 | ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 |
| 41719 | ANTRUM, drainage of, through tooth socket (Anaes.)<br>**Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95 |
| 41722 | OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $513.10 |
| 41725 | ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.)<br>**Fee:** $448.55 **Benefit:** 75% = $336.45 |
| 41728 | LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.)<br>**Fee:** $897.30 **Benefit:** 75% = $673.00 |
| 41729 | DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.)<br>**Fee:** $568.65 **Benefit:** 75% = $426.50 |
| 41731 | FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.)<br>**Fee:** $777.10 **Benefit:** 75% = $582.85 |
| 41734 | RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)<br>**Fee:** $1,014.05 **Benefit:** 75% = $760.55 |
| 41737 | FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.)<br>**Fee:** $483.25 **Benefit:** 75% = $362.45 |
| 41740 | FRONTAL SINUS, catheterisation of (Anaes.)<br>**Fee:** $58.80 **Benefit:** 75% = $44.10 |
| 41743 | FRONTAL SINUS, trephine of (Anaes.) (Assist.)<br>**Fee:** $337.45 **Benefit:** 75% = $253.10 |

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| 41746 | FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.)<br>**Fee:** $777.10 **Benefit:** 75% = $582.85 85% = $702.60 |
| 41749 | ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.)<br>**Fee:** $606.50 **Benefit:** 75% = $454.90 |
| 41752 | SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 |
| 41755 | EUSTACHIAN TUBE, catheterisation of (Anaes.)<br>**Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55 |
| 41758 | DIVISION OF PHARYNGEAL ADHESIONS (Anaes.)<br>**Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95 |
| 41761 | POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.)<br>**Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45 |
| 41764 | NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.)<br>**Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45 |
| 41767 | NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.)<br>**Fee:** $737.00 **Benefit:** 75% = $552.75 85% = $662.50 |
| 41770 | PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)<br>**Fee:** $701.30 **Benefit:** 75% = $526.00 |
| 41773 | PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 |
| 41776 | CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)<br>**Fee:** $585.90 **Benefit:** 75% = $439.45 |
| 41779 | PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)<br>**Fee:** $701.30 **Benefit:** 75% = $526.00 |
| 41782 | PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)<br>**Fee:** $952.10 **Benefit:** 75% = $714.10 85% = $877.60 |
| 41785 | PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.)<br>**Fee:** $1,181.15 **Benefit:** 75% = $885.90 |
| 41786 | UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.)<br>**Fee:** $737.00 **Benefit:** 75% = $552.75 |
| 41787 | 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.)<br>**Fee:** $568.65 **Benefit:** 75% = $426.50 85% = $494.15 |
| 41788 G<br>41789 S | TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.)<br>**Fee:** $219.95 **Benefit:** 75% = $165.00<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 |
| 41792 G<br>41793 S | TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60<br>**Fee:** $371.50 **Benefit:** 75% = $278.65 |
| 41796 G<br>41797 S | TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.)<br>**Fee:** $113.70 **Benefit:** 75% = $85.30<br>**Fee:** $144.00 **Benefit:** 75% = $108.00 |
| 41800 G<br>41801 S | ADENOIDS, removal of (Anaes.)<br>**Fee:** $117.55 **Benefit:** 75% = $88.20<br>**Fee:** $162.95 **Benefit:** 75% = $122.25 |

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| 41804 | LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.)<br>**Fee:** $90.00 **Benefit:** 75% = $67.50 |
| 41807 | PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.)<br>**Fee:** $70.10 **Benefit:** 75% = $52.60 85% = $59.60 |
| 41810 | UVULOTOMY or UVULECTOMY (Anaes.)<br>**Fee:** $35.60 **Benefit:** 75% = $26.70 85% = $30.30 |
| 41813 | VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 41816 | OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.)<br>**Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80 |
| 41819 | DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes.)<br>**Fee:** $348.95 **Benefit:** 75% = $261.75 85% = $296.65 |
| 41820 | DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, where the use of imaging intensification is clinically indicated (Anaes.)<br>**Fee:** $418.75 **Benefit:** 75% = $314.10 85% = $355.95 |
| 41822 | OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.)<br>**Fee:** $238.80 **Benefit:** 75% = $179.10 |
| 41825 | OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 41828 | OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.)<br>**Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40 |
| 41831 | OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes.) (Assist.)<br>**Fee:** $357.00 **Benefit:** 75% = $267.75 85% = $303.45 |
| 41832 | OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.)<br>**Fee:** $228.50 **Benefit:** 75% = $171.40 85% = $194.25 |
| 41834 | LARYNGECTOMY (TOTAL) (Anaes.) (Assist.)<br>**Fee:** $1,289.15 **Benefit:** 75% = $966.90 |
| 41837 | VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)<br>**Fee:** $1,236.05 **Benefit:** 75% = $927.05 |
| 41840 | SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.)<br>**Fee:** $1,519.80 **Benefit:** 75% = $1,139.85 |
| 41843 | LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)<br>**Fee:** $1,336.45 **Benefit:** 75% = $1,002.35 |
| 41846 | LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.)<br>*(See para T8.76 of explanatory notes to this Category)*<br>**Fee:** $185.60 **Benefit:** 75% = $139.20 85% = $157.80 |
| 41849 | LARYNX, direct examination of, with biopsy (Anaes.) (Assist.)<br>**Fee:** $272.90 **Benefit:** 75% = $204.70 |
| 41852 | LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 |
| 41855 | MICROLARYNGOSCOPY (Anaes.) (Assist.)<br>**Fee:** $288.20 **Benefit:** 75% = $216.15 |

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| 41858 | MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.)<br>*(See para T8.77 of explanatory notes to this Category)*<br>**Fee:** $494.15 **Benefit:** 75% = $370.65 |
| 41861 | MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.)<br>**Fee:** $604.30 **Benefit:** 75% = $453.25 |
| 41864 | MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)<br>**Fee:** $407.50 **Benefit:** 75% = $305.65 |
| 41867 | MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.)<br>**Fee:** $613.40 **Benefit:** 75% = $460.05 |
| 41868 | LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes.)<br>**Fee:** $388.70 **Benefit:** 75% = $291.55 |
| 41870 | INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.)<br>**Fee:** $454.85 **Benefit:** 75% = $341.15 |
| 41873 | LARYNX, FRACTURED, operation for (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $513.10 |
| 41876 | LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $513.10 |
| 41879 | LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.)<br>**Fee:** $952.10 **Benefit:** 75% = $714.10 |
| 41880 | TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.)<br>**Fee:** $254.15 **Benefit:** 75% = $190.65 |
| 41881 | TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.)<br>**Fee:** $401.75 **Benefit:** 75% = $301.35 |
| 41884 | CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.)<br>**Fee:** $91.05 **Benefit:** 75% = $68.30 |
| 41885 | TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.)<br>**Fee:** $287.90 **Benefit:** 75% = $215.95 85% = $244.75 |
| 41886 | TRACHEA, removal of foreign body in (Anaes.)<br>**Fee:** $178.05 **Benefit:** 75% = $133.55 85% = $151.35 |
| 41889 | BRONCHOSCOPY, as an independent procedure (Anaes.)<br>**Fee:** $178.05 **Benefit:** 75% = $133.55 85% = $151.35 |
| 41892 | BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.)<br>**Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80 |
| 41895 | BRONCHUS, removal of foreign body in (Anaes.) (Assist.)<br>**Fee:** $367.75 **Benefit:** 75% = $275.85 |
| 41898 | FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.)<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 85% = $218.45 |
| 41901 | ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.)<br>**Fee:** $604.30 **Benefit:** 75% = $453.25 |
| 41904 | BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.)<br>**Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55 |

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| 41905 | TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.)<br>**Fee:** $453.35 **Benefit:** 75% = $340.05 |
| 41907 | NASAL SEPTUM BUTTON, insertion of (Anaes.)<br>**Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45 |
| 41910 | DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.)<br>**Fee:** $390.25 **Benefit:** 75% = $292.70 |
| | *SUBGROUP 9 - OPHTHALMOLOGY* |
| 42503 | OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $102.50 **Benefit:** 75% = $76.90 |
| 42506 | EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.)<br>**Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10 |
| 42509 | EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.)<br>**Fee:** $609.05 **Benefit:** 75% = $456.80 |
| 42510 | EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.)<br>**Fee:** $702.05 **Benefit:** 75% = $526.55 |
| 42512 | GLOBE, EVISCERATION OF (Anaes.) (Assist.)<br>**Fee:** $481.25 **Benefit:** 75% = $360.95 85% = $409.10 |
| 42515 | GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.)<br>**Fee:** $609.05 **Benefit:** 75% = $456.80 |
| 42518 | ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.)<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 |
| 42521 | ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.)<br>**Fee:** $1,203.20 **Benefit:** 75% = $902.40 |
| 42524 | ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.)<br>**Fee:** $204.60 **Benefit:** 75% = $153.45 85% = $173.95 |
| 42527 | CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 |
| 42530 | ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 |
| 42533 | ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 |
| 42536 | ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.)<br>**Fee:** $834.60 **Benefit:** 75% = $625.95 |
| 42539 | ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.)<br>**Fee:** $1,188.20 **Benefit:** 75% = $891.15 |
| 42542 | ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.)<br>**Fee:** $503.85 **Benefit:** 75% = $377.90 |
| 42543 | ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.)<br>**Fee:** $883.85 **Benefit:** 75% = $662.90 |
| 42545 | ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.)<br>**Fee:** $1,278.35 **Benefit:** 75% = $958.80 |

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| 42548 | OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.)<br>**Fee:** $759.40 **Benefit:** 75% = $569.55 |
| 42551 | EYE, PENETRATING WOUND OR RUPTURE OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $557.25 |
| 42554 | EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.)<br>**Fee:** $737.00 **Benefit:** 75% = $552.75 |
| 42557 | EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.)<br>**Fee:** $1,030.20 **Benefit:** 75% = $772.65 |
| 42563 | INTRAOCULAR FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.)<br>**Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $444.50 |
| 42569 | INTRAOCULAR FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.)<br>**Fee:** $1,030.20 **Benefit:** 75% = $772.65 |
| 42572 | ORBITAL ABSCESS OR CYST, drainage of (Anaes.)<br>**Fee:** $117.35 **Benefit:** 75% = $88.05 85% = $99.75 |
| 42573 | DERMOID, periorbital, excision of (Anaes.)<br>**Fee:** $227.45 **Benefit:** 75% = $170.60 85% = $193.35 |
| 42574 | DERMOID, orbital, excision of (Anaes.) (Assist.)<br>**Fee:** $483.25 **Benefit:** 75% = $362.45 85% = $410.80 |
| 42575 | TARSAL CYST, extirpation of (Anaes.)<br>**Fee:** $82.75 **Benefit:** 75% = $62.10 85% = $70.35 |
| 42581 | ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.)<br>**Fee:** $117.35 **Benefit:** 75% = $88.05 85% = $99.75 |
| 42584 | TARSORRHAPHY (Anaes.) (Assist.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30 |
| 42587 | TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.)<br>**Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20 |
| 42590 | CANTHOPLASTY, medial or lateral (Anaes.) (Assist.)<br>**Fee:** $338.35 **Benefit:** 75% = $253.80 85% = $287.60<br>**Extended Medicare Safety Net Cap:** $270.70 |
| 42593 | LACRIMAL GLAND, excision of palpebral lobe (Anaes.)<br>**Fee:** $204.60 **Benefit:** 75% = $153.45 |
| 42596 | LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.)<br>**Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $429.35 |
| 42599 | LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $557.25 |
| 42602 | LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $557.25 |
| 42605 | LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.)<br>**Fee:** $466.10 **Benefit:** 75% = $349.60 85% = $396.20 |
| 42608 | LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 |
| 42610 | NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.)<br>**Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85 |

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| 42611 | NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.)<br>**Fee:** $144.35 | **Benefit:** 75% = $108.30 | 85% = $122.70 |
| 42614 | NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare)<br>**Fee:** $48.30 | **Benefit:** 75% = $36.25 | 85% = $41.10 |
| 42615 | NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare)<br>**Fee:** $72.25 | **Benefit:** 75% = $54.20 | 85% = $61.45 |
| 42617 | PUNCTUM SNIP operation (Anaes.)<br>**Fee:** $136.95 | **Benefit:** 75% = $102.75 | 85% = $116.45 |
| 42620 | PUNCTUM, occlusion of, by use of a plug (Anaes.)<br>**Fee:** $52.65 | **Benefit:** 75% = $39.50 | 85% = $44.80 |
| 42621 | PUNCTUM, temporary occlusion of, by use of electrical cautery (Anaes.)<br>**Fee:** $52.65 | **Benefit:** 75% = $39.50 | 85% = $44.80 |
| 42622 | PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.)<br>**Fee:** $82.75 | **Benefit:** 75% = $62.10 | 85% = $70.35 |
| 42623 | DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.)<br>**Fee:** $699.45 | **Benefit:** 75% = $524.60 | |
| 42626 | DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.)<br>**Fee:** $1,128.05 | **Benefit:** 75% = $846.05 | 85% = $1,053.55 |
| 42629 | CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.)<br>**Fee:** $849.70 | **Benefit:** 75% = $637.30 | |
| 42632 | CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.)<br>**Fee:** $117.35 | **Benefit:** 75% = $88.05 | 85% = $99.75 |
| 42635 | CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.)<br>**Fee:** $300.75 | **Benefit:** 75% = $225.60 | 85% = $255.65 |
| 42638 | CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.)<br>**Fee:** $376.00 | **Benefit:** 75% = $282.00 | 85% = $319.60 |
| 42641 | AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.)<br>**Fee:** $488.75 | **Benefit:** 75% = $366.60 | 85% = $415.45 |
| 42644 | CORNEA OR SCLERA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) (Anaes.)<br>*(See para T8.78 of explanatory notes to this Category)*<br>**Fee:** $72.15 | **Benefit:** 75% = $54.15 | 85% = $61.35 |
| 42647 | CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.)<br>**Fee:** $204.60 | **Benefit:** 75% = $153.45 | 85% = $173.95 |
| 42650 | CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.)<br>**Fee:** $72.15 | **Benefit:** 75% = $54.15 | 85% = $61.35 |
| 42651 | CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.)<br>**Fee:** $160.80 | **Benefit:** 75% = $120.60 | 85% = $136.70 |
| 42653 | CORNEA, transplantation of, full thickness (Anaes.) (Assist.)<br>**Fee:** $1,338.45 | **Benefit:** 75% = $1,003.85 | |
| 42656 | CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.)<br>**Fee:** $1,669.45 | **Benefit:** 75% = $1,252.10 | |

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| 42659 | CORNEA, transplantation of, superficial or lamellar (Anaes.) (Assist.)<br>**Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $827.80 |
| 42662 | SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.)<br>**Fee:** $902.30 **Benefit:** 75% = $676.75 |
| 42665 | SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.)<br>**Fee:** $601.65 **Benefit:** 75% = $451.25 85% = $527.15 |
| 42667 | RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation<br>**Fee:** $141.95 **Benefit:** 75% = $106.50 85% = $120.70 |
| 42668 | CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.)<br>**Fee:** $75.30 **Benefit:** 75% = $56.50 85% = $64.05 |
| 42672 | CORNEAL INCISONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.)<br>*(See para T8.79 of explanatory notes to this Category)*<br>**Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $827.80 |
| 42673 | ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.)<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45 |
| 42676 | CONJUNCTIVA, biopsy of, as an independent procedure<br>**Fee:** $115.70 **Benefit:** 75% = $86.80 85% = $98.35 |
| 42677 | CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.)<br>**Fee:** $60.95 **Benefit:** 75% = $45.75 85% = $51.85 |
| 42680 | CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using $CO^2$ or $N^20$ (Anaes.)<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 |
| 42683 | CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.)<br>**Fee:** $120.35 **Benefit:** 75% = $90.30 |
| 42686 | PTERYGIUM, removal of (Anaes.)<br>**Fee:** $273.65 **Benefit:** 75% = $205.25 85% = $232.65 |
| 42689 | PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.)<br>**Fee:** $117.35 **Benefit:** 75% = $88.05 85% = $99.75 |
| 42692 | LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30 |
| 42695 | LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.)<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45 |
| 42698 | LENS EXTRACTION, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.)<br>*(See para T8.80 of explanatory notes to this Category)*<br>**Fee:** $594.75 **Benefit:** 75% = $446.10 85% = $520.25 |
| 42701 | INTRAOCULAR LENS, insertion of, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.)<br>*(See para T8.80 of explanatory notes to this Category)*<br>**Fee:** $331.70 **Benefit:** 75% = $248.80 85% = $281.95 |
| 42702 | LENS EXTRACTION AND INSERTION OF INTRAOCULAR LENS, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)<br>**Fee:** $760.65 **Benefit:** 75% = $570.50 85% = $686.15<br>**Extended Medicare Safety Net Cap:** $114.10 |

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| 42703 | INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the posterior chamber with fixation to the iris or sclera (Anaes.) (Assist.)<br>**Fee:** $572.05 **Benefit:** 75% = $429.05 85% = $497.55 |
| 42704 | INTRAOCULAR LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.)<br>**Fee:** $466.10 **Benefit:** 75% = $349.60 85% = $396.20 |
| 42707 | INTRAOCULAR LENS, REMOVAL of and REPLACEMENT with a different lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)<br>**Fee:** $797.10 **Benefit:** 75% = $597.85 85% = $722.60 |
| 42710 | INTRAOCULAR LENS, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.)<br>**Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $827.80 |
| 42713 | IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris defect (Anaes.) (Assist.)<br>**Fee:** $376.00 **Benefit:** 75% = $282.00 85% = $319.60 |
| 42716 | CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.)<br>**Fee:** $1,195.70 **Benefit:** 75% = $896.80 85% = $1,121.20 |
| 42719 | REMOVAL OF VITREOUS, and/or CAPSULAR or LENS MATERIAL, via a limbal approach, not being a service associated with a service to which item 42698, 42702, 42716, 42725 or 42731 applies (Anaes.) (Assist.)<br>**Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $444.50 |
| 42725 | VITRECTOMY via pars plana sclerotomies including the removal of vitreous, division of bands or removal of epiretinal membranes (Anaes.) (Assist.)<br>**Fee:** $1,338.45 **Benefit:** 75% = $1,003.85 |
| 42731 | LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy, not being a service associated with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.)<br>**Fee:** $1,519.00 **Benefit:** 75% = $1,139.25 |
| 42734 | CAPSULOTOMY, other than by laser (Anaes.) (Assist.)<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 |
| 42737 | NEEDLING OF POSTERIOR CAPSULE (Anaes.) (Assist.)<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 |
| 42738 | 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.<br>*(See para T8.123 of explanatory notes to this Category)*<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65<br>**Extended Medicare Safety Net Cap:** $240.60 |
| 42739 | 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, for a patient requiring anaesthetic services. (Anaes.)<br>*(See para T8.123 of explanatory notes to this Category)*<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65<br>**Extended Medicare Safety Net Cap:** $240.60 |
| 42740 | INTRAVITREAL INJECTION OF THERAPEUTIC SUBSTANCES, or the removal of vitreous humour for diagnostic purposes, 1 or more of, as a procedure associated with other intraocular surgery. (Anaes.)<br>*(See para T8.123 of explanatory notes to this Category)*<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65<br>**Extended Medicare Safety Net Cap:** $240.60 |
| 42741 | Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.)<br>*(See para T8.81 of explanatory notes to this Category)*<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 |
| 42743 | ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $557.25 |

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| 42744 | NEEDLING FOR DRAINAGE OF ENCYSTED BLEB, following trabeculectomy (Anaes.)<br>**Fee:** $300.55 **Benefit:** 75% = $225.45 85% = $255.50 |
| 42746 | GLAUCOMA, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Anaes.) (Assist.)<br>**Fee:** $955.00 **Benefit:** 75% = $716.25 |
| 42749 | GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.)<br>**Fee:** $1,195.70 **Benefit:** 75% = $896.80 |
| 42752 | GLAUCOMA, insertion of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.) (Assist.)<br>*(See para T8.83 of explanatory notes to this Category)*<br>**Fee:** $1,338.45 **Benefit:** 75% = $1,003.85 |
| 42755 | GLAUCOMA, removal of drainage device incorporating an extraocular reservoir for, such as a Molteno device (Anaes.)<br>**Fee:** $165.45 **Benefit:** 75% = $124.10 85% = $140.65 |
| 42758 | GONIOTOMY (Anaes.) (Assist.)<br>**Fee:** $699.45 **Benefit:** 75% = $524.60 |
| 42761 | DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.)<br>**Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $444.50 |
| 42764 | IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.)<br>**Fee:** $519.00 **Benefit:** 75% = $389.25 85% = $444.50 |
| 42767 | TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.)<br>**Fee:** $1,090.35 **Benefit:** 75% = $817.80 |
| 42770 | CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)<br>*(See para T8.82 of explanatory notes to this Category)*<br>**Fee:** $294.80 **Benefit:** 75% = $221.10 85% = $250.60 |
| 42773 | DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.)<br>**Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $827.80 |
| 42776 | DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.)<br>**Fee:** $1,338.45 **Benefit:** 75% = $1,003.85 |
| 42779 | DETACHED RETINA, revision of scleral buckling operation for (Anaes.) (Assist.)<br>**Fee:** $1,669.45 **Benefit:** 75% = $1,252.10 |
| 42782 | LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.)<br>*(See para T8.84 of explanatory notes to this Category)*<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45 |
| 42783 | LASER TRABECULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye – *where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies*) is indicated in a 2 year period (Anaes.) (Assist.)<br>*(See para T8.84 of explanatory notes to this Category)*<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45 |
| 42785 | LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)<br>*(See para T8.85 of explanatory notes to this Category)*<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35 |
| 42786 | LASER IRIDOTOMY - each treatment episode to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period*** (Anaes.) (Assist.)<br>*(See para T8.85 of explanatory notes to this Category)*<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35 |

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| 42788 | LASER CAPSULOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)<br>*(See para T8.86 of explanatory notes to this Category)*<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35 |
| 42789 | LASER CAPSULOTOMY - each treatment episode to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period*** (Anaes.) (Assist.)<br>*(See para T8.86 of explanatory notes to this Category)*<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35 |
| 42791 | LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS -each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)<br>*(See para T8.87 of explanatory notes to this Category)*<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35 |
| 42792 | LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - each treatment to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period*** (Anaes.) (Assist.)<br>*(See para T8.87 of explanatory notes to this Category)*<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35 |
| 42794 | DIVISION OF SUTURE BY LASER following trabeculoplasty, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)<br>*(See para T8.88 of explanatory notes to this Category)*<br>**Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55 |
| 42797 | LASER COAGULATION OF CORNEAL OR SCLERAL BLOOD VESSELS - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.)<br>*(See para T8.89 of explanatory notes to this Category)*<br>**Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55 |
| 42801 | EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.)<br>**Fee:** $1,049.70 **Benefit:** 75% = $787.30 |
| 42802 | EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.)<br>**Fee:** $524.70 **Benefit:** 75% = $393.55 |
| 42805 | TANTALUM MARKERS, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (Assist.)<br>**Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $512.00 |
| 42806 | IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.)<br>**Fee:** $353.35 **Benefit:** 75% = $265.05 85% = $300.35 |
| 42807 | PHOTOMYDRIASIS, laser<br>**Fee:** $355.80 **Benefit:** 75% = $266.85 85% = $302.45 |
| 42808 | PHOTOIRIDOSYNERESIS, laser<br>**Fee:** $355.80 **Benefit:** 75% = $266.85 85% = $302.45 |
| 42809 | RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45 |
| 42810 | PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.)<br>**Fee:** $567.70 **Benefit:** 75% = $425.80 85% = $493.20 |
| 42811 | TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.)<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45 |
| 42812 | Removal of scleral buckling material, from an eye having undergone previous scleral buckling surgery (Anaes.)<br>**Fee:** $165.45 **Benefit:** 75% = $124.10 85% = $140.65 |

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| 42815 | VITREOUS CAVITY, removal of silicone oil or other liquid vitreous substitutes from, during a procedure other than that in which the vitreous substitute is inserted (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 |
| 42818 | RETINA, CRYOTHERAPY TO, as an independent procedure, or when performed in conjunction with item 42809 or 42770 (Anaes.)<br>**Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $512.00 |
| 42821 | OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.)<br>**Fee:** $90.35 **Benefit:** 75% = $67.80 85% = $76.80 |
| 42824 | RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure<br>**Fee:** $69.90 **Benefit:** 75% = $52.45 85% = $59.45 |
| 42833 | SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.)<br>**Fee:** $586.50 **Benefit:** 75% = $439.90 |
| 42836 | SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)<br>**Fee:** $729.45 **Benefit:** 75% = $547.10 |
| 42839 | SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.)<br>**Fee:** $699.45 **Benefit:** 75% = $524.60 |
| 42842 | SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)<br>**Fee:** $872.30 **Benefit:** 75% = $654.25 |
| 42845 | READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.)<br>*(See para T8.90 of explanatory notes to this Category)*<br>**Fee:** $189.40 **Benefit:** 75% = $142.05 85% = $161.00 |
| 42848 | SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.)<br>**Fee:** $699.45 **Benefit:** 75% = $524.60 |
| 42851 | SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.)<br>**Fee:** $872.30 **Benefit:** 75% = $654.25 |
| 42854 | RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15 |
| 42857 | RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15 |
| 42860 | EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.)<br>**Fee:** $902.30 **Benefit:** 75% = $676.75 85% = $827.80 |
| 42863 | EYELID, recession of (Anaes.) (Assist.)<br>**Fee:** $774.55 **Benefit:** 75% = $580.95 85% = $700.05 |
| 42866 | 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.)<br>**Fee:** $751.85 **Benefit:** 75% = $563.90 85% = $677.35 |
| 42869 | EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.)<br>**Fee:** $549.00 **Benefit:** 75% = $411.75 85% = $474.50 |

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| 42872 | EYEBROW, elevation of, for paretic states (Anaes.)<br>**Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60 |
| 43021 | Photodynamic therapy, one eye, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation.<br>**Fee:** $455.05 **Benefit:** 75% = $341.30 85% = $386.80 |
| 43022 | Photodynamic therapy, both eyes, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation.<br>**Fee:** $546.15 **Benefit:** 75% = $409.65 85% = $471.65 |
| 43023 | Infusion of Verteporfin for discontinued photodynamic therapy, where a session of therapy which would have been provided under item 43021 or 43022 has been discontinued on medical grounds.<br>**Fee:** $88.50 **Benefit:** 75% = $66.40 85% = $75.25 |
| | *SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS* |
| | *ACUTE* |
| 43500 | OPERATION ON PHALANX (Anaes.)<br>**Fee:** $123.35 **Benefit:** 75% = $92.55 |
| 43503 | OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.)<br>**Fee:** $204.70 **Benefit:** 75% = $153.55 |
| 43506 | OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 43509 | OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| | *CHRONIC* |
| 43512 | OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 43515 | OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90 |
| 43518 | OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 |
| 43521 | OPERATION ON SKULL (Anaes.) (Assist.)<br>**Fee:** $464.50 **Benefit:** 75% = $348.40 |
| 43524 | OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $513.10 |
| | *SUBGROUP 11 - PAEDIATRIC* |
| | *SURGERY IN NEONATE OR YOUNG CHILD* |
| 43801 | INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.)<br>**Fee:** $957.30 **Benefit:** 75% = $718.00 |
| 43804 | INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.)<br>**Fee:** $1,019.25 **Benefit:** 75% = $764.45 |
| 43807 | DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.)<br>**Fee:** $1,112.00 **Benefit:** 75% = $834.00 |

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| 43810 | JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.)<br>**Fee:** $1,297.35 **Benefit:** 75% = $973.05 |
| 43813 | MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.)<br>**Fee:** $1,297.35 **Benefit:** 75% = $973.05 |
| 43816 | ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.)<br>**Fee:** $1,204.60 **Benefit:** 75% = $903.45 |
| 43819 | HIRSCHSPRUNG'S DISEASE, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.)<br>**Fee:** $972.95 **Benefit:** 75% = $729.75 |
| 43822 | ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)<br>**Fee:** $972.95 **Benefit:** 75% = $729.75 |
| 43825 | NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.)<br>**Fee:** $1,112.00 **Benefit:** 75% = $834.00 |
| 43828 | ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.)<br>**Fee:** $1,228.55 **Benefit:** 75% = $921.45 |
| 43831 | ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.)<br>**Fee:** $957.30 **Benefit:** 75% = $718.00 |
| 43834 | BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.)<br>**Fee:** $1,112.00 **Benefit:** 75% = $834.00 |
| 43837 | CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.)<br>**Fee:** $1,389.90 **Benefit:** 75% = $1,042.45 |
| 43840 | CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.)<br>**Fee:** $1,204.60 **Benefit:** 75% = $903.45 |
| 43843 | OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.)<br>**Fee:** $1,853.35 **Benefit:** 75% = $1,390.05 |
| 43846 | OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.)<br>**Fee:** $1,992.30 **Benefit:** 75% = $1,494.25 |
| 43849 | OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.)<br>**Fee:** $509.65 **Benefit:** 75% = $382.25 |
| 43852 | OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,621.55 **Benefit:** 75% = $1,216.20 85% = $1,547.05 |
| 43855 | OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.)<br>**Fee:** $1,714.35 **Benefit:** 75% = $1,285.80 |
| 43858 | OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.)<br>**Fee:** $602.25 **Benefit:** 75% = $451.70 85% = $527.75 |
| 43861 | CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.)<br>**Fee:** $1,668.05 **Benefit:** 75% = $1,251.05 |
| 43864 | GASTROSCHISIS, operation for (Anaes.) (Assist.)<br>**Fee:** $1,251.05 **Benefit:** 75% = $938.30 |

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| 43867 | GASTROSCHISIS, secondary operation for, with removal of silo and closure of abdominal wall (Anaes.) (Assist.)<br>**Fee:** $695.00 **Benefit:** 75% = $521.25 |
| 43870 | EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.)<br>**Fee:** $972.95 **Benefit:** 75% = $729.75 |
| 43873 | EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.)<br>**Fee:** $1,297.35 **Benefit:** 75% = $973.05 |
| 43876 | SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.)<br>**Fee:** $1,112.00 **Benefit:** 75% = $834.00 |
| 43879 | SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.)<br>**Fee:** $1,297.35 **Benefit:** 75% = $973.05 |
| 43882 | CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.)<br>**Fee:** $1,668.05 **Benefit:** 75% = $1,251.05 85% = $1,593.55 |
| | *THORACIC SURGERY* |
| 43900 | TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.)<br>**Fee:** $1,112.00 **Benefit:** 75% = $834.00 |
| 43903 | OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.)<br>**Fee:** $1,853.35 **Benefit:** 75% = $1,390.05 |
| 43906 | OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.)<br>**Fee:** $1,621.55 **Benefit:** 75% = $1,216.20 |
| 43909 | TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.)<br>**Fee:** $1,621.55 **Benefit:** 75% = $1,216.20 |
| 43912 | THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.)<br>**Fee:** $1,532.00 **Benefit:** 75% = $1,149.00 |
| 43915 | EVENTRATION, plication of diaphragm for (Anaes.) (Assist.)<br>**Fee:** $1,158.30 **Benefit:** 75% = $868.75 85% = $1,083.80 |
| | *ABDOMINAL SURGERY* |
| 43930 | HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.)<br>**Fee:** $445.40 **Benefit:** 75% = $334.05 |
| 43933 | IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.)<br>**Fee:** $521.40 **Benefit:** 75% = $391.05 |
| 43936 | INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.)<br>**Fee:** $972.95 **Benefit:** 75% = $729.75 |
| 43939 | VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.)<br>**Fee:** $741.30 **Benefit:** 75% = $556.00 |
| 43942 | ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.)<br>**Fee:** $231.70 **Benefit:** 75% = $173.80 85% = $196.95 |
| 43945 | PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.)<br>**Fee:** $972.95 **Benefit:** 75% = $729.75 |
| 43948 | UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.)<br>**Fee:** $139.10 **Benefit:** 75% = $104.35 85% = $118.25 |
| 43951 | GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.)<br>**Fee:** $871.30 **Benefit:** 75% = $653.50 |

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| 43954 | GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.)<br>**Fee:** $1,065.75 **Benefit:** 75% = $799.35 |
| 43957 | GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)<br>**Fee:** $1,158.30 **Benefit:** 75% = $868.75 |
| 43960 | ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.)<br>**Fee:** $407.50 **Benefit:** 75% = $305.65 |
| 43963 | ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)<br>**Fee:** $1,621.55 **Benefit:** 75% = $1,216.20 |
| 43966 | ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.)<br>**Fee:** $1,853.35 **Benefit:** 75% = $1,390.05 |
| 43969 | PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.)<br>**Fee:** $2,548.35 **Benefit:** 75% = $1,911.30 |
| 43972 | CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)<br>**Fee:** $1,853.35 **Benefit:** 75% = $1,390.05 |
| 43975 | CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)<br>**Fee:** $2,177.70 **Benefit:** 75% = $1,633.30 |
| 43978 | BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.)<br>**Fee:** $1,853.35 **Benefit:** 75% = $1,390.05 |
| 43981 | NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.)<br>**Fee:** $509.65 **Benefit:** 75% = $382.25 |
| 43984 | NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.)<br>**Fee:** $1,297.35 **Benefit:** 75% = $973.05 |
| 43987 | NEUROBLASTOMA, radical excision of (Anaes.) (Assist.)<br>**Fee:** $1,436.40 **Benefit:** 75% = $1,077.30 |
| 43990 | HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.)<br>**Fee:** $1,760.75 **Benefit:** 75% = $1,320.60 |
| 43993 | HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.)<br>**Fee:** $1,899.65 **Benefit:** 75% = $1,424.75 85% = $1,825.15 |
| 43996 | HIRSCHPRUNG'S DISEASE, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.)<br>**Fee:** $2,131.35 **Benefit:** 75% = $1,598.55 85% = $2,056.85 |
| 43999 | HIRSCHSPRUNG'S DISEASE, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)<br>**Fee:** $266.55 **Benefit:** 75% = $199.95 |
| 44102 | RECTUM, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.)<br>**Fee:** $256.95 **Benefit:** 75% = $192.75 |
| 44105 | RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, under general anaesthesia (Anaes.)<br>**Fee:** $45.10 **Benefit:** 75% = $33.85 85% = $38.35 |
| 44108 | INGUINAL HERNIA repair at age less than 3 months (Anaes.) (Assist.)<br>**Fee:** $491.45 **Benefit:** 75% = $368.60 |

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| 44111 | OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair of, at age less than 3 months, including orchidopexy when performed (Anaes.) (Assist.)<br>**Fee:** $575.65 **Benefit:** 75% = $431.75 85% = $501.15 |
| 44114 | INGUINAL HERNIA repair at age less than 3 months when orchidopexy also required (Anaes.) (Assist.)<br>**Fee:** $575.65 **Benefit:** 75% = $431.75 |
| | *MISCELLANEOUS SURGERY* |
| 44130 | LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.)<br>**Fee:** $463.30 **Benefit:** 75% = $347.50 85% = $393.85 |
| 44133 | TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.)<br>**Fee:** $367.75 **Benefit:** 75% = $275.85 |
| 44136 | INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| | *SUBGROUP 12 - AMPUTATIONS* |
| 44325 | HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35 |
| 44328 | HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 44331 | AMPUTATION AT SHOULDER (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 |
| 44334 | INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.)<br>**Fee:** $1,194.25 **Benefit:** 75% = $895.70 85% = $1,119.75 |
| 44338 | 1 DIGIT of foot, amputation of (Anaes.)<br>**Fee:** $144.00 **Benefit:** 75% = $108.00 85% = $122.40 |
| 44342 | 2 DIGITS of 1 foot, amputation of (Anaes.)<br>**Fee:** $219.95 **Benefit:** 75% = $165.00 |
| 44346 | 3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.)<br>**Fee:** $254.00 **Benefit:** 75% = $190.50 |
| 44350 | 4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.)<br>**Fee:** $288.20 **Benefit:** 75% = $216.15 85% = $245.00 |
| 44354 | 5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.)<br>**Fee:** $329.80 **Benefit:** 75% = $247.35 |
| 44358 | TOE, including metatarsal or part of metatarsal each toe , amputation of (Anaes.)<br>**Fee:** $183.90 **Benefit:** 75% = $137.95 |
| 44359 | ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare (Anaes.) (Assist.)<br>**Fee:** $263.95 **Benefit:** 75% = $198.00 |
| 44361 | FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 |
| 44364 | FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.)<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 |
| 44367 | AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.)<br>**Fee:** $521.95 **Benefit:** 75% = $391.50 |
| 44370 | AMPUTATION AT HIP (Anaes.) (Assist.)<br>**Fee:** $720.20 **Benefit:** 75% = $540.15 |

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| 44373 | HINDQUARTER, amputation of (Anaes.) (Assist.)<br>**Fee:** $1,478.40 **Benefit:** 75% = $1,108.80 85% = $1,403.90 |
| 44376 | AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.)<br>**Derived Fee:** 75% of the original amputation fee |
| | *SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY* |
| | *GENERAL* |
| 45000 | **METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR**<br>*(Note: See Explanatory notes to this Category for definition of "Local skin flap")*<br>SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.)<br>**Fee:** $541.35 **Benefit:** 75% = $406.05 85% = $466.85 |
| 45003 | SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (Anaes.)<br>**Fee:** $601.65 **Benefit:** 75% = $451.25 85% = $527.15<br>**Extended Medicare Safety Net Cap:** $481.35 |
| 45006 | SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.)<br>**Fee:** $1,037.65 **Benefit:** 75% = $778.25 |
| 45009 | SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.)<br>**Fee:** $379.05 **Benefit:** 75% = $284.30 |
| 45012 | SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.)<br>**Fee:** $635.00 **Benefit:** 75% = $476.25 |
| 45015 | MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.)<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 |
| 45018 | DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.)<br>**Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65 |
| 45019 | FULL FACE CHEMICAL PEEL **for severely sun-damaged skin,** ***where it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin,*** where at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.)<br>*(See para T8.91 of explanatory notes to this Category)*<br>**Fee:** $396.70 **Benefit:** 75% = $297.55 |
| 45020 | FULL FACE CHEMICAL PEEL **for severe chloasma or melasma refractory to all other treatments**, ***where it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres***, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.)<br>*(See para T8.91 of explanatory notes to this Category)*<br>**Fee:** $396.70 **Benefit:** 75% = $297.55 85% = $337.20 |
| 45021 | ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)<br>*(See para T8.92 of explanatory notes to this Category)*<br>**Fee:** $177.35 **Benefit:** 75% = $133.05 85% = $150.75 |
| 45024 | ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)<br>*(See para T8.92 of explanatory notes to this Category)*<br>**Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80 |

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| 45025 | CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)<br>*(See para T8.92 of explanatory notes to this Category)*<br>**Fee:** $177.35 **Benefit:** 75% = $133.05 85% = $150.75<br>**Extended Medicare Safety Net Cap:** $141.90 |
| 45026 | CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)<br>*(See para T8.92 of explanatory notes to this Category)*<br>**Fee:** $398.55 **Benefit:** 75% = $298.95 85% = $338.80<br>**Extended Medicare Safety Net Cap:** $318.85 |
| 45027 | ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $120.35 **Benefit:** 75% = $90.30 85% = $102.30 |
| 45030 | ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.)<br>**Fee:** $129.25 **Benefit:** 75% = $96.95 85% = $109.90 |
| 45033 | ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.)<br>**Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60 |
| 45035 | ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.)<br>**Fee:** $702.05 **Benefit:** 75% = $526.55 |
| 45036 | ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.)<br>**Fee:** $1,128.05 **Benefit:** 75% = $846.05 |
| 45039 | ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.)<br>**Fee:** $240.70 **Benefit:** 75% = $180.55 85% = $204.60 |
| 45042 | ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.)<br>**Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15 |
| 45045 | ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)<br>**Fee:** $308.40 **Benefit:** 75% = $231.30 85% = $262.15 |
| 45048 | LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.)<br>**Fee:** $774.55 **Benefit:** 75% = $580.95 |
| 45051 | CONTOUR RECONSTRUCTION for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (Anaes.) (Assist.)<br>*(See para T8.93 of explanatory notes to this Category)*<br>**Fee:** $473.75 **Benefit:** 75% = $355.35 |
| 45054 | LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.)<br>*(See para T8.94 of explanatory notes to this Category)*<br>**Fee:** $246.10 **Benefit:** 75% = $184.60 |
| | *SKIN FLAP SURGERY* |
| 45200 | *(Note: See Explanatory notes to this Category for definition of "Local skin flap")*<br>SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.)<br>*(See para T8.95 of explanatory notes to this Category)*<br>**Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70<br>**Extended Medicare Safety Net Cap:** $227.50 |
| 45203 | SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) (Assist.)<br>*(See para T8.95 of explanatory notes to this Category)*<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15<br>**Extended Medicare Safety Net Cap:** $324.85 |

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| 45206 | SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, and excluding H-flap or double advancement flap (Anaes.)<br>*(See para T8.95 of explanatory notes to this Category)*<br>**Fee:** $383.55 **Benefit:** 75% = $287.70 85% = $326.05<br>**Extended Medicare Safety Net Cap:** $306.85 |
| 45207 | H-FLAP OR DOUBLE ADVANCEMENT FLAP where indicated to repair 1 defect, on eyelid, eyebrow or forehead (Anaes.)<br>**Fee:** $383.55 **Benefit:** 75% = $287.70 85% = $326.05 |
| 45209 | DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)<br>**Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70 |
| 45212 | DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.)<br>**Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80 |
| 45215 | DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.)<br>**Fee:** $1,014.05 **Benefit:** 75% = $760.55 |
| 45218 | DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.)<br>**Fee:** $454.85 **Benefit:** 75% = $341.15 |
| 45221 | DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.)<br>**Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35 |
| 45224 | DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.)<br>**Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95 |
| 45227 | INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.)<br>**Fee:** $445.40 **Benefit:** 75% = $334.05 85% = $378.60 |
| 45230 | DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.)<br>**Fee:** $222.75 **Benefit:** 75% = $167.10 85% = $189.35 |
| 45233 | INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.)<br>**Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70 |
| 45236 | INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.)<br>**Fee:** $371.50 **Benefit:** 75% = $278.65 |
| 45239 | DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.)<br>**Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35 |
| 45240 | DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.)<br>**Fee:** $261.55 **Benefit:** 75% = $196.20 85% = $222.35 |
| | *FREE GRAFTS* |
| 45400 | FREE GRAFTING (split skin) of a granulating area, small (Anaes.)<br>**Fee:** $204.70 **Benefit:** 75% = $153.55 85% = $174.00 |
| 45403 | FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.)<br>**Fee:** $407.50 **Benefit:** 75% = $305.65 85% = $346.40 |
| 45406 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.)<br>*(See para T8.96 of explanatory notes to this Category)*<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 85% = $383.45 |
| 45409 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (Anaes.) (Assist.)<br>*(See para T8.96 of explanatory notes to this Category)*<br>**Fee:** $601.65 **Benefit:** 75% = $451.25 |

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| 45412 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.)<br>*(See para T8.96 of explanatory notes to this Category)*<br>**Fee:** $827.30 **Benefit:** 75% = $620.50 |
| 45415 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.)<br>*(See para T8.96 of explanatory notes to this Category)*<br>**Fee:** $902.30 **Benefit:** 75% = $676.75 |
| 45418 | 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.)<br>*(See para T8.96 of explanatory notes to this Category)*<br>**Fee:** $977.55 **Benefit:** 75% = $733.20 |
| 45439 | FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.)<br>**Fee:** $284.35 **Benefit:** 75% = $213.30 85% = $241.70 |
| 45442 | FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.)<br>**Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $512.00 |
| 45445 | 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.)<br>**Fee:** $556.60 **Benefit:** 75% = $417.45 85% = $482.10 |
| 45448 | FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.)<br>**Fee:** $376.00 **Benefit:** 75% = $282.00 85% = $319.60 |
| 45451 | FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.)<br>**Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70 |
| 45460 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.)<br>**Fee:** $1,253.30 **Benefit:** 75% = $940.00 |
| 45461 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $893.25 **Benefit:** 75% = $669.95 |
| 45462 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, co- surgeon** (Assist.)<br>**Fee:** $674.05 **Benefit:** 75% = $505.55 |
| 45464 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.)<br>**Fee:** $1,913.10 **Benefit:** 75% = $1,434.85 |
| 45465 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $1,363.00 **Benefit:** 75% = $1,022.25 85% = $1,288.50 |
| 45466 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.)<br>**Fee:** $1,027.95 **Benefit:** 75% = $771.00 85% = $953.45 |
| 45468 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $1,832.65 **Benefit:** 75% = $1,374.50 |
| 45469 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.)<br>**Fee:** $1,382.70 **Benefit:** 75% = $1,037.05 85% = $1,308.20 |
| 45471 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $2,303.65 **Benefit:** 75% = $1,727.75 85% = $2,229.15 |

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| 45472 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.)<br>**Fee:** $1,737.60 **Benefit:** 75% = $1,303.20 85% = $1,663.10 |
| 45474 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $2,773.30 **Benefit:** 75% = $2,080.00 85% = $2,698.80 |
| 45475 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.)<br>**Fee:** $2,092.45 **Benefit:** 75% = $1,569.35 85% = $2,017.95 |
| 45477 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $3,243.00 **Benefit:** 75% = $2,432.25 85% = $3,168.50 |
| 45478 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.)<br>**Fee:** $2,446.05 **Benefit:** 75% = $1,834.55 85% = $2,371.55 |
| 45480 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $3,712.60 **Benefit:** 75% = $2,784.45 85% = $3,638.10 |
| 45481 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.)<br>**Fee:** $2,801.10 **Benefit:** 75% = $2,100.85 85% = $2,726.60 |
| 45483 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.)<br>**Fee:** $4,229.95 **Benefit:** 75% = $3,172.50 85% = $4,155.45 |
| 45484 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, co-surgeon** (Assist.)<br>**Fee:** $3,191.50 **Benefit:** 75% = $2,393.65 85% = $3,117.00 |
| 45485 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.)<br>**Fee:** $527.70 **Benefit:** 75% = $395.80 |
| 45486 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.)<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 |
| 45487 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15 |
| 45488 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.)<br>**Fee:** $451.10 **Benefit:** 75% = $338.35 |
| 45489 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.)<br>**Fee:** $676.80 **Benefit:** 75% = $507.60 85% = $602.30 |
| 45490 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.)<br>**Fee:** $902.50 **Benefit:** 75% = $676.90 |
| 45491 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.)<br>**Fee:** $1,128.05 **Benefit:** 75% = $846.05 |
| 45492 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.)<br>**Fee:** $1,353.60 **Benefit:** 75% = $1,015.20 |
| 45493 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 |
| 45494 | FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.)<br>**Fee:** $1,638.70 **Benefit:** 75% = $1,229.05 85% = $1,564.20 |

| | *OTHER GRAFTS AND MISCELLANEOUS PROCEDURES* |
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| 45496 | FLAP, free tissue transfer using microvascular techniques - ***revision of***, by open operation (Anaes.)<br>**Fee:** $416.05 **Benefit:** 75% = $312.05 |
| 45497 | FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***complete revision of***, by liposuction (Anaes.)<br>**Fee:** $324.95 **Benefit:** 75% = $243.75 |
| 45498 | FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***staged revision of***, by liposuction - first stage (Anaes.)<br>**Fee:** $261.55 **Benefit:** 75% = $196.20 |
| 45499 | FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***staged revision of***, by liposuction - second stage (Anaes.)<br>**Fee:** $195.00 **Benefit:** 75% = $146.25 |
| 45500 | MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.)<br>**Fee:** $1,090.35 **Benefit:** 75% = $817.80 |
| 45501 | MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.)<br>**Fee:** $1,774.70 **Benefit:** 75% = $1,331.05 |
| 45502 | MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.)<br>**Fee:** $1,774.70 **Benefit:** 75% = $1,331.05 |
| 45503 | MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $2,030.35 **Benefit:** 75% = $1,522.80 |
| 45504 | MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.)<br>**Fee:** $1,774.70 **Benefit:** 75% = $1,331.05 |
| 45505 | MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.)<br>**Fee:** $1,774.70 **Benefit:** 75% = $1,331.05 |
| 45506 | SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.)<br>*(See para T8.97 of explanatory notes to this Category)*<br>**Fee:** $219.95 **Benefit:** 75% = $165.00 85% = $187.00 |
| 45512 | SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.)<br>*(See para T8.97 of explanatory notes to this Category)*<br>**Fee:** $295.70 **Benefit:** 75% = $221.80 85% = $251.35 |
| 45515 | SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or where performed by a specialist in the practice of his or her specialty (Anaes.)<br>*(See para T8.97 of explanatory notes to this Category)*<br>**Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55 |
| 45518 | SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.)<br>*(See para T8.97 of explanatory notes to this Category)*<br>**Fee:** $225.70 **Benefit:** 75% = $169.30 85% = $191.85 |
| 45519 | EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.)<br>**Fee:** $429.05 **Benefit:** 75% = $321.80 |
| 45520 | REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes.) (Assist.)<br>**Fee:** $900.45 **Benefit:** 75% = $675.35 |

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| 45522 | REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (Anaes.) (Assist.)<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 |
| 45524 | MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.) (Assist.)<br>*(See para T8.98 of explanatory notes to this Category)*<br>**Fee:** $741.65 **Benefit:** 75% = $556.25 |
| 45527 | MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.)<br>*(See para T8.98 of explanatory notes to this Category)*<br>**Fee:** $741.65 **Benefit:** 75% = $556.25 |
| 45528 | MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45527 applies, ***where it can be demonstrated*** that surgery is indicated because of malformation of breast tissue (excluding hypomastia), disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.)<br>*(See para T8.98 of explanatory notes to this Category)*<br>**Fee:** $1,112.35 **Benefit:** 75% = $834.30 |
| 45530 | BREAST RECONSTRUCTION (unilateral) using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174 or 30177 applies (Anaes.) (Assist.)<br>*(See para T8.99 of explanatory notes to this Category)*<br>**Fee:** $1,099.40 **Benefit:** 75% = $824.55 |
| 45533 | BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.)<br>**Fee:** $1,245.10 **Benefit:** 75% = $933.85 |
| 45536 | BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.)<br>**Fee:** $457.85 **Benefit:** 75% = $343.40 |
| 45539 | BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)<br>**Fee:** $1,071.20 **Benefit:** 75% = $803.40 |
| 45542 | BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)<br>**Fee:** $613.40 **Benefit:** 75% = $460.05 |
| 45545 | NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)<br>*(See para T8.102 of explanatory notes to this Category)*<br>**Fee:** $622.55 **Benefit:** 75% = $466.95 85% = $548.05<br>**Extended Medicare Safety Net Cap:** $498.05 |
| 45546 | NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple<br>*(See para T8.102 of explanatory notes to this Category)*<br>**Fee:** $197.85 **Benefit:** 75% = $148.40 85% = $168.20 |
| 45548 | BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30 |
| 45551 | BREAST PROSTHESIS, removal of, with excision of fibrous capsule (Anaes.) (Assist.)<br>**Fee:** $443.70 **Benefit:** 75% = $332.80 |
| 45552 | BREAST PROSTHESIS, removal of, with excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.)<br>*(See para T8.100 of explanatory notes to this Category)*<br>**Fee:** $638.65 **Benefit:** 75% = $479.00 85% = $564.15 |
| 45553 | BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation). (Anaes.) (Assist.)<br>*(See para T8.100 of explanatory notes to this Category)*<br>**Fee:** $638.65 **Benefit:** 75% = $479.00 85% = $564.15 |

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| 45554 | BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (Anaes.) (Assist.)<br>*(See para T8.100 of explanatory notes to this Category)*<br>**Fee:** $699.45 **Benefit:** 75% = $524.60 85% = $624.95 |
| 45555 | SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.) (Assist.)<br>*(See para T8.100 of explanatory notes to this Category)*<br>**Fee:** $638.65 **Benefit:** 75% = $479.00 |
| 45556 | BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (Anaes.) (Assist.)<br>*(See para T8.101 of explanatory notes to this Category)*<br>**Fee:** $766.05 **Benefit:** 75% = $574.55 |
| 45557 | BREAST PTOSIS, correction of by mastopexy by any means (unilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove, not being a service associated with a service to which item 45522 applies (Anaes.) (Assist.)<br>*(See para T8.101 of explanatory notes to this Category)*<br>**Fee:** $766.05 **Benefit:** 75% = $574.55 |
| 45558 | BREAST PTOSIS, correction of by mastopexy by any means (bilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove, not being a service associated with a service to which item 45522 applies (Anaes.) (Assist.)<br>*(See para T8.101 of explanatory notes to this Category)*<br>**Fee:** $1,148.95 **Benefit:** 75% = $861.75 |
| 45559 | TUBEROUS, TUBULAR OR CONSTRICTED BREAST, **where it can be demonstrated,** correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.)<br>*(See para T8.101 of explanatory notes to this Category)*<br>**Fee:** $1,136.80 **Benefit:** 75% = $852.60 85% = $1,062.30 |
| 45560 | HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.)<br>**Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65<br>**Extended Medicare Safety Net Cap:** $165.80 |
| 45561 | MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.)<br>**Fee:** $1,774.70 **Benefit:** 75% = $1,331.05 |
| 45562 | FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)<br>**Fee:** $1,099.40 **Benefit:** 75% = $824.55 85% = $1,024.90 |
| 45563 | NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)<br>**Fee:** $1,099.40 **Benefit:** 75% = $824.55 85% = $1,024.90 |
| 45564 | FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.)<br>**Fee:** $2,546.30 **Benefit:** 75% = $1,909.75 |
| 45565 | FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.)<br>**Fee:** $1,909.80 **Benefit:** 75% = $1,432.35 |

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| 45566 | TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)<br>**Fee:** $1,071.20 **Benefit:** 75% = $803.40 |
| 45568 | TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)<br>**Fee:** $443.70 **Benefit:** 75% = $332.80 |
| 45569 | CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)<br>**Fee:** $677.60 **Benefit:** 75% = $508.20 |
| 45570 | CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)<br>**Fee:** $914.95 **Benefit:** 75% = $686.25 85% = $840.45 |
| 45572 | 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.)<br>**Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $247.95 |
| 45575 | FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.)<br>**Fee:** $720.20 **Benefit:** 75% = $540.15 85% = $645.70 |
| 45578 | FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.)<br>**Fee:** $834.05 **Benefit:** 75% = $625.55 |
| 45581 | FACIAL NERVE PALSY, excision of tissue for (Anaes.)<br>**Fee:** $276.80 **Benefit:** 75% = $207.60 85% = $235.30 |
| 45584 | LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.)<br>*(See para T8.103 of explanatory notes to this Category)*<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $557.25<br>**Extended Medicare Safety Net Cap:** $505.40 |
| 45585 | LIPOSUCTION (suction assisted lipolysis) to 1 regional area, not being a service associated with a service to which item 31521 or 31527 applies, where it can be demonstrated that the treatment is for Barraquer-Simon's Syndrome (pathological lipodystrophy of hips, buttocks, thighs, knees or lower legs), lymphoedema or macrodystrophia lipomatosa (Anaes.)<br>*(See para T8.103 of explanatory notes to this Category)*<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 85% = $557.25<br>**Extended Medicare Safety Net Cap:** $505.40 |
| 45586 | LIPOSUCTION (suction assisted lipolysis) for reduction of a buffalo hump, ***where it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition*** (Anaes.)<br>*(See para T8.103 of explanatory notes to this Category)*<br>**Fee:** $631.75 **Benefit:** 75% = $473.85 |
| 45587 | MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.) (Assist.)<br>*(See para T8.104 of explanatory notes to this Category)*<br>**Fee:** $890.85 **Benefit:** 75% = $668.15 85% = $816.35<br>**Extended Medicare Safety Net Cap:** $712.70 |
| 45588 | MELOPLASTY, (excluding browlifts and chinlift platysmaplasties), bilateral ***where it can be demonstrated*** that surgery is indicated because of congenital conditions, disease or trauma (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.)<br>*(See para T8.104 of explanatory notes to this Category)*<br>**Fee:** $1,336.40 **Benefit:** 75% = $1,002.30 |
| 45590 | ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.)<br>**Fee:** $483.25 **Benefit:** 75% = $362.45 |
| 45593 | ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.)<br>**Fee:** $567.65 **Benefit:** 75% = $425.75 |
| 45596 | MAXILLA, total resection of (Anaes.) (Assist.)<br>**Fee:** $900.45 **Benefit:** 75% = $675.35 |

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| 45597 | MAXILLA, total resection of both maxillae (Anaes.) (Assist.)<br>**Fee:** $1,205.40 **Benefit:** 75% = $904.05 |
| 45599 | MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.)<br>**Fee:** $936.55 **Benefit:** 75% = $702.45 85% = $862.05 |
| 45602 | MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)<br>**Fee:** $699.45 **Benefit:** 75% = $524.60 |
| 45605 | MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 |
| 45608 | MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)<br>**Fee:** $827.30 **Benefit:** 75% = $620.50 |
| 45611 | MANDIBLE, condylectomy (Anaes.) (Assist.)<br>**Fee:** $473.75 **Benefit:** 75% = $355.35 |
| 45614 | EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $513.10<br>**Extended Medicare Safety Net Cap:** $470.10 |
| 45617 | UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes.)<br>*(See para T8.105 of explanatory notes to this Category)*<br>**Fee:** $235.05 **Benefit:** 75% = $176.30 85% = $199.80<br>**Extended Medicare Safety Net Cap:** $188.05 |
| 45620 | LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes.)<br>*(See para T8.105 of explanatory notes to this Category)*<br>**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15<br>**Extended Medicare Safety Net Cap:** $260.85 |
| 45623 | PTOSIS of eyelid (unilateral), correction of (Anaes.) (Assist.)<br>**Fee:** $723.05 **Benefit:** 75% = $542.30 85% = $648.55<br>**Extended Medicare Safety Net Cap:** $578.45 |
| 45624 | PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes.) (Assist.)<br>**Fee:** $937.40 **Benefit:** 75% = $703.05 85% = $862.90<br>**Extended Medicare Safety Net Cap:** $749.95 |
| 45625 | PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.)<br>**Fee:** $187.55 **Benefit:** 75% = $140.70 |
| 45626 | ECTROPION OR ENTROPION, correction of (unilateral) (Anaes.)<br>**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15 |
| 45629 | SYMBLEPHARON, grafting for (Anaes.) (Assist.)<br>**Fee:** $473.75 **Benefit:** 75% = $355.35 85% = $402.70 |
| 45632 | RHINOPLASTY, correction of lateral or alar cartilages (Anaes.)<br>**Fee:** $511.95 **Benefit:** 75% = $384.00 85% = $437.45<br>**Extended Medicare Safety Net Cap:** $409.60 |
| 45635 | RHINOPLASTY, correction of bony vault only (Anaes.)<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $513.10<br>**Extended Medicare Safety Net Cap:** $470.10 |
| 45638 | RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity ***(but not as a result of previous elective cosmetic surgery),*** or both (Anaes.)<br>*(See para T8.106 of explanatory notes to this Category)*<br>**Fee:** $1,014.05 **Benefit:** 75% = $760.55 |

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| 45639 | RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, ***where it can be demonstrated*** that there is a need for correction of significant developmental deformity (Anaes.)<br>*(See para T8.106 of explanatory notes to this Category)*<br>**Fee:** $1,014.05 **Benefit:** 75% = $760.55 |
| 45641 | RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes.)<br>**Fee:** $1,082.90 **Benefit:** 75% = $812.20 |
| 45644 | RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes.) (Assist.)<br>**Fee:** $1,279.45 **Benefit:** 75% = $959.60 |
| 45645 | CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.)<br>**Fee:** $223.60 **Benefit:** 75% = $167.70 |
| 45646 | CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.)<br>**Fee:** $900.45 **Benefit:** 75% = $675.35 85% = $825.95 |
| 45647 | FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.)<br>*(See para T8.107 of explanatory notes to this Category)*<br>**Fee:** $1,279.45 **Benefit:** 75% = $959.60 |
| 45650 | RHINOPLASTY, secondary revision of (Anaes.)<br>**Fee:** $147.80 **Benefit:** 75% = $110.85 85% = $125.65 |
| 45652 | RHINOPHYMA, carbon dioxide laser or erbium laser excision-ablation of (Anaes.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90<br>**Extended Medicare Safety Net Cap:** $285.10 |
| 45653 | RHINOPHYMA, shaving of (Anaes.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90 |
| 45656 | COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.)<br>**Fee:** $502.25 **Benefit:** 75% = $376.70 85% = $427.75 |
| 45659 | LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 85% = $446.75<br>**Extended Medicare Safety Net Cap:** $417.00 |
| 45660 | EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)<br>**Fee:** $2,878.75 **Benefit:** 75% = $2,159.10 |
| 45661 | EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.)<br>**Fee:** $1,279.45 **Benefit:** 75% = $959.60 |
| 45662 | CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.)<br>**Fee:** $701.30 **Benefit:** 75% = $526.00 |
| 45665 | LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.)<br>**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15 |
| 45668 | VERMILIONECTOMY, by surgical excision (Anaes.)<br>**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15 |
| 45669 | VERMILIONECTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.)<br>*(See para T8.108 of explanatory notes to this Category)*<br>**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15 |
| 45671 | LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)<br>**Fee:** $834.05 **Benefit:** 75% = $625.55 85% = $759.55 |

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| 45674 | LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)<br>**Fee:** $242.55 **Benefit:** 75% = $181.95 85% = $206.20 |
| 45675 | MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.)<br>**Fee:** $483.25 **Benefit:** 75% = $362.45 |
| 45676 | MACROSTOMIA, operation for (Anaes.) (Assist.)<br>**Fee:** $575.30 **Benefit:** 75% = $431.50 |
| 45677 | CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)<br>**Fee:** $541.35 **Benefit:** 75% = $406.05 |
| 45680 | CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)<br>**Fee:** $676.80 **Benefit:** 75% = $507.60 |
| 45683 | CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)<br>**Fee:** $751.85 **Benefit:** 75% = $563.90 |
| 45686 | CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)<br>**Fee:** $887.50 **Benefit:** 75% = $665.65 |
| 45689 | CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.)<br>**Fee:** $261.75 **Benefit:** 75% = $196.35 |
| 45692 | CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 |
| 45695 | CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)<br>**Fee:** $488.75 **Benefit:** 75% = $366.60 |
| 45698 | CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.)<br>**Fee:** $458.75 **Benefit:** 75% = $344.10 |
| 45701 | CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)<br>**Fee:** $827.30 **Benefit:** 75% = $620.50 |
| 45704 | CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)<br>**Fee:** $300.75 **Benefit:** 75% = $225.60 85% = $255.65 |
| 45707 | CLEFT PALATE, primary repair (Anaes.) (Assist.)<br>**Fee:** $781.95 **Benefit:** 75% = $586.50 |
| 45710 | CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.)<br>**Fee:** $488.75 **Benefit:** 75% = $366.60 |
| 45713 | CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.)<br>**Fee:** $556.60 **Benefit:** 75% = $417.45 |
| 45714 | ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.)<br>**Fee:** $781.95 **Benefit:** 75% = $586.50 |
| 45716 | VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.)<br>**Fee:** $781.95 **Benefit:** 75% = $586.50 |
| 45720 | MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and excluding services to which item 47933or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $966.80 **Benefit:** 75% = $725.10 85% = $892.30 |
| 45723 | 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.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,090.35 **Benefit:** 75% = $817.80 |

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| 45726 | MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,232.05 **Benefit:** 75% = $924.05 |
| 45729 | MANDIBLE OR MAXILLA, bilateral 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.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,383.65 **Benefit:** 75% = $1,037.75 |
| 45731 | MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,402.70 **Benefit:** 75% = $1,052.05 |
| 45732 | MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,579.20 **Benefit:** 75% = $1,184.40 |
| 45735 | MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,611.05 **Benefit:** 75% = $1,208.30 |
| 45738 | MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,812.40 **Benefit:** 75% = $1,359.30 |
| 45741 | MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,772.30 **Benefit:** 75% = $1,329.25 |
| 45744 | MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,992.70 **Benefit:** 75% = $1,494.55 |
| 45747 | MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $1,933.55 **Benefit:** 75% = $1,450.20 85% = $1,859.05 |
| 45752 | MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>*(See para T8.109 of explanatory notes to this Category)*<br>**Fee:** $2,165.75 **Benefit:** 75% = $1,624.35 |
| 45753 | MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)<br>**Fee:** $2,178.60 **Benefit:** 75% = $1,633.95 85% = $2,104.10 |

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| 45754 | MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)<br>**Fee:** $2,611.60 **Benefit:** 75% = $1,958.70 |
| 45755 | TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)<br>**Fee:** $367.75 **Benefit:** 75% = $275.85 85% = $312.60 |
| 45758 | TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.)<br>**Fee:** $658.05 **Benefit:** 75% = $493.55 |
| 45761 | GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)<br>*(See para T8.110 of explanatory notes to this Category)*<br>**Fee:** $748.65 **Benefit:** 75% = $561.50 |
| 45767 | HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.)<br>**Fee:** $2,511.65 **Benefit:** 75% = $1,883.75 85% = $2,437.15 |
| 45770 | HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.)<br>**Fee:** $1,923.90 **Benefit:** 75% = $1,442.95 |
| 45773 | TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.)<br>**Fee:** $1,753.40 **Benefit:** 75% = $1,315.05 85% = $1,678.90 |
| 45776 | ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.)<br>**Fee:** $1,753.40 **Benefit:** 75% = $1,315.05 |
| 45779 | ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)<br>**Fee:** $1,289.15 **Benefit:** 75% = $966.90 |
| 45782 | FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)<br>**Fee:** $985.70 **Benefit:** 75% = $739.30 85% = $911.20 |
| 45785 | CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.)<br>**Fee:** $1,668.10 **Benefit:** 75% = $1,251.10 |
| 45788 | GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.)<br>**Fee:** $1,649.10 **Benefit:** 75% = $1,236.85 |
| 45791 | ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.)<br>**Fee:** $890.85 **Benefit:** 75% = $668.15 |
| 45794 | OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)<br>**Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $429.35 |
| 45797 | OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.)<br>**Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55 |
| | *ORAL AND MAXILLOFACIAL SURGERY* |
| 45799 | 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.)<br>**Fee:** $29.45 **Benefit:** 75% = $22.10 85% = $25.05 |
| 45801 | TUMOUR, CYST, ULCER OR SCAR, (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, not being a service to which item 45803 applies (Anaes.)<br>*(See para T8.111 of explanatory notes to this Category)*<br>**Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90 |

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| 45803 | 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.)<br>*(See para T8.111 of explanatory notes to this Category)*<br>**Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $277.15 |
| 45805 | TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.)<br>*(See para T8.111 of explanatory notes to this Category)*<br>**Fee:** $172.50 **Benefit:** 75% = $129.40 85% = $146.65 |
| 45807 | 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.)<br>*(See para T8.111 of explanatory notes to this Category)*<br>**Fee:** $246.50 **Benefit:** 75% = $184.90 85% = $209.55 |
| 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.)<br>*(See para T8.111 of explanatory notes to this Category)*<br>**Fee:** $371.50 **Benefit:** 75% = $278.65 85% = $315.80 |
| 45811 | 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.)<br>*(See para T8.111 of explanatory notes to this Category)*<br>**Fee:** $502.25 **Benefit:** 75% = $376.70 85% = $427.75 |
| 45813 | TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)<br>*(See para T8.111 of explanatory notes to this Category)*<br>**Fee:** $587.60 **Benefit:** 75% = $440.70 85% = $513.10 |
| 45815 | OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.)<br>**Fee:** $356.35 **Benefit:** 75% = $267.30 85% = $302.90 |
| 45817 | OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.)<br>**Fee:** $464.50 **Benefit:** 75% = $348.40 85% = $394.85 |
| 45819 | OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.)<br>**Fee:** $587.55 **Benefit:** 75% = $440.70 85% = $513.05 |
| 45821 | BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.)<br>**Fee:** $380.80 **Benefit:** 75% = $285.60 85% = $323.70 |
| 45823 | 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.)<br>**Fee:** $108.90 **Benefit:** 75% = $81.70 85% = $92.60 |
| 45825 | MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)<br>**Fee:** $338.35 **Benefit:** 75% = $253.80 85% = $287.60 |
| 45827 | MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.)<br>**Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90 |
| 45829 | MAXILLARY TUBEROSITY, reduction of (Anaes.)<br>**Fee:** $246.70 **Benefit:** 75% = $185.05 85% = $209.70 |
| 45831 | PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.)<br>**Fee:** $323.40 **Benefit:** 75% = $242.55 85% = $274.90 |

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| 45833 | PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.)<br>**Fee:** $406.05 **Benefit:** 75% = $304.55 85% = $345.15 |
| 45835 | PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.)<br>**Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $429.35 |
| 45837 | VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)<br>**Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $512.00 |
| 45839 | FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.)<br>**Fee:** $586.50 **Benefit:** 75% = $439.90 85% = $512.00 |
| 45841 | ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.)<br>**Fee:** $473.65 **Benefit:** 75% = $355.25 85% = $402.65 |
| 45843 | ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)<br>**Fee:** $290.50 **Benefit:** 75% = $217.90 85% = $246.95 |
| 45845 | 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.)<br>**Fee:** $503.85 **Benefit:** 75% = $377.90 85% = $429.35 |
| 45847 | 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.)<br>**Fee:** $186.50 **Benefit:** 75% = $139.90 85% = $158.55 |
| 45849 | MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.)<br>**Fee:** $580.90 **Benefit:** 75% = $435.70 85% = $506.40 |
| 45851 | 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.)<br>**Fee:** $142.95 **Benefit:** 75% = $107.25 85% = $121.55 |
| 45853 | ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)<br>**Fee:** $890.85 **Benefit:** 75% = $668.15 85% = $816.35 |
| 45855 | TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.)<br>**Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40 |
| 45857 | TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment 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.)<br>**Fee:** $653.80 **Benefit:** 75% = $490.35 85% = $579.30 |
| 45859 | TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 85% = $280.20 |
| 45861 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $872.30 **Benefit:** 75% = $654.25 85% = $797.80 |
| 45863 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $967.00 **Benefit:** 75% = $725.25 85% = $892.50 |
| 45865 | ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)<br>**Fee:** $290.50 **Benefit:** 75% = $217.90 85% = $246.95 |

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| 45867 | TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)<br>**Fee:** $312.30 | **Benefit:** 75% = $234.25 | 85% = $265.50 |
| 45869 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $1,188.20 | **Benefit:** 75% = $891.15 | 85% = $1,113.70 |
| 45871 | TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $1,338.45 | **Benefit:** 75% = $1,003.85 | 85% = $1,263.95 |
| 45873 | TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.)<br>**Fee:** $1,504.05 | **Benefit:** 75% = $1,128.05 | 85% = $1,429.55 |
| 45875 | TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)<br>**Fee:** $470.70 | **Benefit:** 75% = $353.05 | 85% = $400.10 |
| 45877 | TEMPOROMANDIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)<br>**Fee:** $470.70 | **Benefit:** 75% = $353.05 | 85% = $400.10 |
| 45879 | TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)<br>**Fee:** $312.30 | **Benefit:** 75% = $234.25 | 85% = $265.50 |
| 45882 | The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser.<br>**Fee:** $43.00 | **Benefit:** 75% = $32.25 | 85% = $36.55 |
| 45885 | Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.)<br>**Fee:** $443.70 | **Benefit:** 75% = $332.80 | 85% = $377.15 |
| 45888 | FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.)<br>**Fee:** $413.55 | **Benefit:** 75% = $310.20 | 85% = $351.55 |
| 45891 | SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.)<br>**Fee:** $602.45 | **Benefit:** 75% = $451.85 | 85% = $527.95 |
| 45894 | FREE GRAFTING, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.)<br>**Fee:** $204.70 | **Benefit:** 75% = $153.55 | 85% = $174.00 |
| 45897 | ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.)<br>**Fee:** $1,069.10 | **Benefit:** 75% = $801.85 | 85% = $994.60 |
| 45900 | MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity<br>**Fee:** $241.15 | **Benefit:** 75% = $180.90 | 85% = $205.00 |
| 45939 | PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.)<br>**Fee:** $447.10 | **Benefit:** 75% = $335.35 | 85% = $380.05 |
| 45945 | MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.)<br>**Fee:** $118.70 | **Benefit:** 75% = $89.05 | 85% = $100.90 |
| 45975 | MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $129.20 | **Benefit:** 75% = $96.90 | 85% = $109.85 |
| 45978 | MANDIBLE, treatment of fracture of, not requiring splinting<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $157.85 | **Benefit:** 75% = $118.40 | 85% = $134.20 |

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| 45981 | ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $85.65 | **Benefit:** 75% = $64.25 | 85% = $72.85 |
| 45984 | MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.)<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $616.65 | **Benefit:** 75% = $462.50 | 85% = $542.15 |
| 45987 | MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.)<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $616.65 | **Benefit:** 75% = $462.50 | 85% = $542.15 |
| 45990 | MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $842.25 | **Benefit:** 75% = $631.70 | 85% = $767.75 |
| 45993 | MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $842.25 | **Benefit:** 75% = $631.70 | 85% = $767.75 |
| 45996 | MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.)<br>*(See para T8.112 of explanatory notes to this Category)*<br>**Fee:** $238.80 | **Benefit:** 75% = $179.10 | 85% = $203.00 |
| | *SUBGROUP 14 - HAND SURGERY* | | |
| 46300 | *Note: Items 46300 to 46534 are restricted to surgery on the hand/s.*<br><br>INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $338.40 | **Benefit:** 75% = $253.80 | |
| 46303 | CARPOMETACARPAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $376.10 | **Benefit:** 75% = $282.10 | |
| 46306 | INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.)<br>**Fee:** $526.50 | **Benefit:** 75% = $394.90 | |
| 46307 | INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.)<br>**Fee:** $526.50 | **Benefit:** 75% = $394.90 | |
| 46309 | INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.)<br>**Fee:** $526.50 | **Benefit:** 75% = $394.90 | |
| 46312 | INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.)<br>**Fee:** $676.95 | **Benefit:** 75% = $507.75 | |
| 46315 | INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.)<br>**Fee:** $902.55 | **Benefit:** 75% = $676.95 | |
| 46318 | INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.)<br>**Fee:** $1,128.25 | **Benefit:** 75% = $846.20 | |
| 46321 | INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.) (Assist.)<br>**Fee:** $1,353.90 | **Benefit:** 75% = $1,015.45 | 85% = $1,279.40 |

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| 46324 | CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.)<br>**Fee:** $807.35 **Benefit:** 75% = $605.55 |
| 46325 | CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.)<br>**Fee:** $842.50 **Benefit:** 75% = $631.90 |
| 46327 | INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.)<br>**Fee:** $203.15 **Benefit:** 75% = $152.40 85% = $172.70 |
| 46330 | INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy (Anaes.) (Assist.)<br>**Fee:** $346.10 **Benefit:** 75% = $259.60 |
| 46333 | INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.)<br>**Fee:** $564.05 **Benefit:** 75% = $423.05 |
| 46336 | INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.)<br>**Fee:** $263.30 **Benefit:** 75% = $197.50 85% = $223.85 |
| 46339 | EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.)<br>**Fee:** $466.20 **Benefit:** 75% = $349.65 85% = $396.30 |
| 46342 | DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.)<br>**Fee:** $466.20 **Benefit:** 75% = $349.65 |
| 46345 | DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.)<br>**Fee:** $564.05 **Benefit:** 75% = $423.05 |
| 46348 | DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.)<br>**Fee:** $244.45 **Benefit:** 75% = $183.35 85% = $207.80 |
| 46351 | DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.)<br>**Fee:** $364.80 **Benefit:** 75% = $273.60 |
| 46354 | DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.)<br>**Fee:** $488.85 **Benefit:** 75% = $366.65 |
| 46357 | DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.)<br>**Fee:** $609.20 **Benefit:** 75% = $456.90 85% = $534.70 |
| 46360 | DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.)<br>**Fee:** $733.35 **Benefit:** 75% = $550.05 |
| 46363 | TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.)<br>**Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $179.05 |
| 46366 | DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.)<br>**Fee:** $127.90 **Benefit:** 75% = $95.95 85% = $108.75 |
| 46369 | DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.)<br>**Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $179.05 |
| 46372 | DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.) (Assist.)<br>**Fee:** $427.95 **Benefit:** 75% = $321.00 85% = $363.80 |
| 46375 | DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.)<br>**Fee:** $507.70 **Benefit:** 75% = $380.80 85% = $433.20 |
| 46378 | DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.)<br>**Fee:** $676.95 **Benefit:** 75% = $507.75 |

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| 46381 | INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes.) (Assist.)<br>**Fee:** $300.80 **Benefit:** 75% = $225.60 |
| 46384 | Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.)<br>**Fee:** $300.80 **Benefit:** 75% = $225.60 |
| 46387 | DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.)<br>**Fee:** $620.60 **Benefit:** 75% = $465.45 85% = $546.10 |
| 46390 | DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.)<br>**Fee:** $827.50 **Benefit:** 75% = $620.65 |
| 46393 | DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.)<br>**Fee:** $959.00 **Benefit:** 75% = $719.25 |
| 46396 | PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 85% = $280.20 |
| 46399 | PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.)<br>**Fee:** $517.80 **Benefit:** 75% = $388.35 |
| 46402 | PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.)<br>**Fee:** $517.80 **Benefit:** 75% = $388.35 |
| 46405 | PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.)<br>**Fee:** $631.90 **Benefit:** 75% = $473.95 |
| 46408 | TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.)<br>**Fee:** $692.00 **Benefit:** 75% = $519.00 |
| 46411 | FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.)<br>**Fee:** $406.15 **Benefit:** 75% = $304.65 |
| 46414 | ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.)<br>**Fee:** $526.40 **Benefit:** 75% = $394.80 85% = $451.90 |
| 46417 | TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.)<br>**Fee:** $488.85 **Benefit:** 75% = $366.65 |
| 46420 | EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.)<br>**Fee:** $204.60 **Benefit:** 75% = $153.45 85% = $173.95 |
| 46423 | EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.)<br>**Fee:** $327.15 **Benefit:** 75% = $245.40 85% = $278.10 |
| 46426 | FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.)<br>**Fee:** $338.40 **Benefit:** 75% = $253.80 |
| 46429 | FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.)<br>**Fee:** $413.65 **Benefit:** 75% = $310.25 85% = $351.65 |
| 46432 | FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)<br>**Fee:** $451.35 **Benefit:** 75% = $338.55 |
| 46435 | FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)<br>**Fee:** $526.50 **Benefit:** 75% = $394.90 |
| 46438 | MALLET FINGER, closed pin fixation of (Anaes.)<br>**Fee:** $135.45 **Benefit:** 75% = $101.60 85% = $115.15 |

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| 46441 | MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.)<br>**Fee:** $327.15 **Benefit:** 75% = $245.40 85% = $278.10 |
| 46442 | MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.)<br>**Fee:** $280.85 **Benefit:** 75% = $210.65 |
| 46444 | BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.)<br>**Fee:** $488.85 **Benefit:** 75% = $366.65 |
| 46447 | BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.)<br>**Fee:** $609.20 **Benefit:** 75% = $456.90 |
| 46450 | EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.)<br>**Fee:** $225.70 **Benefit:** 75% = $169.30 |
| 46453 | FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.)<br>**Fee:** $376.10 **Benefit:** 75% = $282.10 |
| 46456 | FINGER, percutaneous tenotomy of (Anaes.)<br>**Fee:** $97.80 **Benefit:** 75% = $73.35 85% = $83.15 |
| 46459 | OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.)<br>**Fee:** $188.05 **Benefit:** 75% = $141.05 85% = $159.85 |
| 46462 | OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.)<br>**Fee:** $300.80 **Benefit:** 75% = $225.60 85% = $255.70 |
| 46464 | AMPUTATION of a supernumerary complete digit (Anaes.)<br>**Fee:** $225.70 **Benefit:** 75% = $169.30 85% = $191.85 |
| 46465 | AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)<br>**Fee:** $225.70 **Benefit:** 75% = $169.30 85% = $191.85 |
| 46468 | AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)<br>**Fee:** $394.90 **Benefit:** 75% = $296.20 |
| 46471 | AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)<br>**Fee:** $564.05 **Benefit:** 75% = $423.05 85% = $489.55 |
| 46474 | AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)<br>**Fee:** $733.35 **Benefit:** 75% = $550.05 |
| 46477 | AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)<br>**Fee:** $902.55 **Benefit:** 75% = $676.95 |
| 46480 | AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.)<br>**Fee:** $376.10 **Benefit:** 75% = $282.10 85% = $319.70 |
| 46483 | REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.)<br>**Fee:** $300.80 **Benefit:** 75% = $225.60 85% = $255.70 |
| 46486 | NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $225.70 **Benefit:** 75% = $169.30 85% = $191.85 |
| 46489 | NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)<br>**Fee:** $263.30 **Benefit:** 75% = $197.50 85% = $223.85 |

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| 46492 | CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.)<br>**Fee:** $361.05 | **Benefit:** 75% = $270.80 | |
| 46494 | GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $219.95 | **Benefit:** 75% = $165.00 | 85% = $187.00 |
| 46495 | GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)<br>**Fee:** $203.15 | **Benefit:** 75% = $152.40 | 85% = $172.70 |
| 46498 | GANGLION OF FLEXOR TENDON SHEATH, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.)<br>**Fee:** $219.95 | **Benefit:** 75% = $165.00 | 85% = $187.00 |
| 46500 | GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)<br>**Fee:** $263.30 | **Benefit:** 75% = $197.50 | 85% = $223.85 |
| 46501 | GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)<br>**Fee:** $329.20 | **Benefit:** 75% = $246.90 | 85% = $279.85 |
| 46502 | RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)<br>**Fee:** $302.95 | **Benefit:** 75% = $227.25 | 85% = $257.55 |
| 46503 | RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.)<br>**Fee:** $378.40 | **Benefit:** 75% = $283.80 | 85% = $321.65 |
| 46504 | NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.)<br>**Fee:** $1,105.55 | **Benefit:** 75% = $829.20 | 85% = $1,031.05 |
| 46507 | DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.)<br>**Fee:** $1,286.20 | **Benefit:** 75% = $964.65 | |
| 46510 | MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.)<br>**Fee:** $351.00 | **Benefit:** 75% = $263.25 | |
| 46513 | DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.)<br>**Fee:** $56.50 | **Benefit:** 75% = $42.40 | 85% = $48.05 |
| 46516 | DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital (Anaes.)<br>**Fee:** $112.85 | **Benefit:** 75% = $84.65 | 85% = $95.95 |
| 46519 | MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.)<br>**Fee:** $141.25 | **Benefit:** 75% = $105.95 | 85% = $120.10 |
| 46522 | FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.)<br>**Fee:** $421.20 | **Benefit:** 75% = $315.90 | |
| 46525 | PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after-care) (Anaes.)<br>**Fee:** $56.50 | **Benefit:** 75% = $42.40 | 85% = $48.05 |
| 46528 | INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)<br>**Fee:** $169.50 | **Benefit:** 75% = $127.15 | 85% = $144.10 |
| 46531 | INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.)<br>**Fee:** $85.15 | **Benefit:** 75% = $63.90 | 85% = $72.40 |
| 46534 | NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.)<br>**Fee:** $235.50 | **Benefit:** 75% = $176.65 | 85% = $200.20 |

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| | *SUBGROUP 15 - ORTHOPAEDIC* |
| | *TREATMENT OF DISLOCATIONS* |
| 47000 | MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10 |
| 47003 | CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10 |
| 47006 | CLAVICLE, treatment of dislocation of, by open reduction (Anaes.)<br>**Fee:** $170.25 **Benefit:** 75% = $127.70 85% = $144.75 |
| 47009 | SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47012 | SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.)<br>**Fee:** $338.85 **Benefit:** 75% = $254.15 |
| 47015 | SHOULDER, treatment of dislocation of, not requiring general anaesthesia<br>**Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10 |
| 47018 | ELBOW, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00 |
| 47021 | ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 |
| 47024 | RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.)<br>**Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00 |
| 47027 | RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 |
| 47030 | CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00 |
| 47033 | CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10 |
| 47036 | INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10 |
| 47039 | INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47042 | METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47045 | METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)<br>**Fee:** $150.75 **Benefit:** 75% = $113.10 85% = $128.15 |
| 47048 | HIP, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10 |
| 47051 | HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 |
| 47054 | KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.)<br>**Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10 |
| 47057 | PATELLA, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $127.00 **Benefit:** 75% = $95.25 85% = $107.95 |

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| 47060 | PATELLA, treatment of dislocation of, by open reduction (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47063 | ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $254.20 **Benefit:** 75% = $190.65 85% = $216.10 |
| 47066 | ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $338.85 **Benefit:** 75% = $254.15 |
| 47069 | TOE, treatment of dislocation of, by closed reduction (Anaes.)<br>**Fee:** $70.65 **Benefit:** 75% = $53.00 85% = $60.10 |
| 47072 | TOE, treatment of dislocation of, by open reduction (Anaes.)<br>**Fee:** $94.00 **Benefit:** 75% = $70.50 85% = $79.90 |
| | *TREATMENT OF FRACTURES* |
| 47300 | DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.)<br>**Fee:** $84.80 **Benefit:** 75% = $63.60 85% = $72.10 |
| 47303 | DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.)<br>**Fee:** $98.90 **Benefit:** 75% = $74.20 85% = $84.10 |
| 47306 | DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47309 | DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes.)<br>**Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10 |
| 47312 | MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $127.00 **Benefit:** 75% = $95.25 85% = $107.95 |
| 47315 | MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes.)<br>**Fee:** $145.95 **Benefit:** 75% = $109.50 85% = $124.10 |
| 47318 | MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47321 | MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes.)<br>**Fee:** $211.75 **Benefit:** 75% = $158.85 |
| 47324 | PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47327 | PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.)<br>**Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00 |
| 47330 | PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47333 | PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 |
| 47336 | METACARPAL, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47339 | METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes.)<br>**Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00 |
| 47342 | METACARPAL, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47345 | METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 |

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| 47348 | CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.)<br>**Fee:** $94.00 **Benefit:** 75% = $70.50 85% = $79.90 |
| 47351 | CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47354 | CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47357 | CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10 |
| 47360 | RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (Anaes.)<br>**Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10 |
| 47363 | RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $197.60 **Benefit:** 75% = $148.20 85% = $168.00 |
| 47366 | RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10 |
| 47369 | RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47372 | RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 85% = $240.00 |
| 47375 | RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 47378 | RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47381 | RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $254.20 **Benefit:** 75% = $190.65 85% = $216.10 |
| 47384 | RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $338.85 **Benefit:** 75% = $254.15 |
| 47385 | RADIUS OR ULNA, shaft of, 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.)<br>**Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00 |
| 47386 | RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 |
| 47387 | RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05 |
| 47390 | RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $409.55 **Benefit:** 75% = $307.20 |
| 47393 | RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $546.00 **Benefit:** 75% = $409.50 |
| 47396 | OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.)<br>**Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00 |

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| 47399 | OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 47402 | OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 85% = $240.00 |
| 47405 | RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.)<br>**Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00 |
| 47408 | RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 47411 | HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47414 | HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47417 | HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10 |
| 47420 | HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.)<br>**Fee:** $517.80 **Benefit:** 75% = $388.35 |
| 47423 | HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.)<br>**Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05 |
| 47426 | HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10 |
| 47429 | HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 |
| 47432 | HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $541.30 **Benefit:** 75% = $406.00 |
| 47435 | HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)<br>**Fee:** $414.25 **Benefit:** 75% = $310.70 85% = $352.15 |
| 47438 | HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.)<br>**Fee:** $659.15 **Benefit:** 75% = $494.40 |
| 47441 | HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.)<br>**Fee:** $823.75 **Benefit:** 75% = $617.85 |
| 47444 | HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47447 | HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $338.85 **Benefit:** 75% = $254.15 |
| 47450 | HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)<br>**Fee:** $451.95 **Benefit:** 75% = $339.00 |
| 47451 | HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.)<br>**Fee:** $544.80 **Benefit:** 75% = $408.60 |
| 47453 | HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10 |
| 47456 | HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)<br>**Fee:** $395.50 **Benefit:** 75% = $296.65 85% = $336.20 |

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| 47459 | HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)<br>**Fee:** $527.25 **Benefit:** 75% = $395.45 |
| 47462 | CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47465 | CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47466 | STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47467 | STERNUM, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 |
| 47468 | SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 85% = $368.05 |
| 47471 | RIBS (1 or more), treatment of fracture of - each attendance<br>**Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 |
| 47474 | PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum<br>**Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00 |
| 47477 | PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47480 | PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 |
| 47483 | PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.)<br>**Fee:** $564.85 **Benefit:** 75% = $423.65 |
| 47486 | PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 47489 | PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.)<br>**Fee:** $1,412.20 **Benefit:** 75% = $1,059.15 |
| 47492 | ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47495 | ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10 |
| 47498 | ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.)<br>**Fee:** $706.05 **Benefit:** 75% = $529.55 |
| 47501 | ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 47504 | ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $1,412.20 **Benefit:** 75% = $1,059.15 85% = $1,337.70 |
| 47507 | ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $1,412.20 **Benefit:** 75% = $1,059.15 |

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| 47510 | ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $1,412.20 **Benefit:** 75% = $1,059.15 |
| 47513 | SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 47516 | FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 85% = $368.05 |
| 47519 | FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.)<br>**Fee:** $866.20 **Benefit:** 75% = $649.65 |
| 47522 | FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 47525 | FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.)<br>**Fee:** $866.20 **Benefit:** 75% = $649.65 |
| 47528 | FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 47531 | FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.)<br>**Fee:** $960.25 **Benefit:** 75% = $720.20 |
| 47534 | FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 47537 | FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 85% = $368.05 |
| 47540 | HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.)<br>**Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05 |
| 47543 | TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47546 | TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)<br>**Fee:** $338.85 **Benefit:** 75% = $254.15 85% = $288.05 |
| 47549 | TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $451.95 **Benefit:** 75% = $339.00 |
| 47552 | TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10 |
| 47555 | TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)<br>**Fee:** $564.85 **Benefit:** 75% = $423.65 |
| 47558 | TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 47561 | TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05 |
| 47564 | TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.)<br>**Fee:** $409.55 **Benefit:** 75% = $307.20 85% = $348.15 |
| 47565 | TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)<br>**Fee:** $712.40 **Benefit:** 75% = $534.30 |

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| 47566 | TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.)<br>**Fee:** $908.05 **Benefit:** 75% = $681.05 |
| 47567 | TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)<br>**Fee:** $475.35 **Benefit:** 75% = $356.55 85% = $404.05 |
| 47570 | TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)<br>**Fee:** $546.00 **Benefit:** 75% = $409.50 85% = $471.50 |
| 47573 | TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.)<br>**Fee:** $682.55 **Benefit:** 75% = $511.95 |
| 47576 | FIBULA, treatment of fracture of (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47579 | PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)<br>**Fee:** $160.05 **Benefit:** 75% = $120.05 85% = $136.05 |
| 47582 | PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 47585 | PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.)<br>**Fee:** $423.75 **Benefit:** 75% = $317.85 |
| 47588 | KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 47591 | KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.)<br>**Fee:** $1,600.65 **Benefit:** 75% = $1,200.50 |
| 47594 | ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.)<br>**Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05 |
| 47597 | ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $324.80 **Benefit:** 75% = $243.60 85% = $276.10 |
| 47600 | ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 |
| 47603 | ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.)<br>**Fee:** $564.85 **Benefit:** 75% = $423.65 |
| 47606 | CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47609 | CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)<br>**Fee:** $353.05 **Benefit:** 75% = $264.80 85% = $300.10 |
| 47612 | CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)<br>**Fee:** $409.55 **Benefit:** 75% = $307.20 85% = $348.15 |
| 47615 | CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 85% = $400.10 |
| 47618 | CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)<br>**Fee:** $588.45 **Benefit:** 75% = $441.35 |
| 47621 | TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)<br>**Fee:** $409.55 **Benefit:** 75% = $307.20 85% = $348.15 |

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| 47624 | TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)<br>**Fee:** $564.85 **Benefit:** 75% = $423.65 |
| 47627 | TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.)<br>**Fee:** $160.05 **Benefit:** 75% = $120.05 85% = $136.05 |
| 47630 | TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)<br>**Fee:** $338.85 **Benefit:** 75% = $254.15 85% = $288.05 |
| 47633 | METATARSAL, 1 of, treatment of fracture of (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47636 | METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47639 | METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47642 | METATARSALS, 2 of, treatment of fracture of (Anaes.)<br>**Fee:** $150.75 **Benefit:** 75% = $113.10 85% = $128.15 |
| 47645 | METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $226.00 **Benefit:** 75% = $169.50 85% = $192.10 |
| 47648 | METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $301.05 **Benefit:** 75% = $225.80 |
| 47651 | METATARSALS, 3 or more of, treatment of fracture of (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47654 | METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.)<br>**Fee:** $353.05 **Benefit:** 75% = $264.80 85% = $300.10 |
| 47657 | METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 |
| 47663 | PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.)<br>**Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10 |
| 47666 | PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47672 | PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47678 | PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47681 | SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance<br>**Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 |
| 47684 | SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers or halo (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 85% = $678.75 |
| 47687 | SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, with immobilisation by calipers or halo, and including up to 14 days post-operative care (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 47690 | SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation (Anaes.) (Assist.)<br>**Fee:** $1,035.55 **Benefit:** 75% = $776.70 |
| 47693 | SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |

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| 47696 | SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10 |
| 47699 | SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.)<br>**Fee:** $1,506.45 **Benefit:** 75% = $1,129.85 |
| 47702 | SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Anaes.) (Assist.)<br>**Fee:** $1,882.95 **Benefit:** 75% = $1,412.25 |
| 47703 | SKULL, treatment of fracture of, each attendance<br>**Fee:** $43.00 **Benefit:** 75% = $32.25 85% = $36.55 |
| 47705 | SKULL CALIPERS, insertion of, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 |
| 47708 | PLASTER JACKET, application of, as an independent procedure (Anaes.)<br>**Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05 |
| 47711 | HALO, application of, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $320.15 **Benefit:** 75% = $240.15 |
| 47714 | HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)<br>**Fee:** $240.05 **Benefit:** 75% = $180.05 |
| 47717 | HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes.) (Assist.)<br>**Fee:** $423.75 **Benefit:** 75% = $317.85 |
| 47720 | HALO-FEMORAL TRACTION, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $423.75 **Benefit:** 75% = $317.85 85% = $360.20 |
| 47723 | HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes.) (Assist.)<br>**Fee:** $423.75 **Benefit:** 75% = $317.85 85% = $360.20 |
| 47726 | BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.)<br>**Fee:** $141.25 **Benefit:** 75% = $105.95 |
| 47729 | BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 |
| 47732 | VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 47735 | NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance<br>**Fee:** $43.05 **Benefit:** 75% = $32.30 85% = $36.60 |
| 47738 | NASAL BONES, treatment of fracture of, by reduction (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47741 | NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.)<br>**Fee:** $480.35 **Benefit:** 75% = $360.30 |
| 47753 | MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)<br>**Fee:** $406.65 **Benefit:** 75% = $305.00 |
| 47756 | MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)<br>**Fee:** $406.65 **Benefit:** 75% = $305.00 |
| 47762 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)<br>**Fee:** $238.80 **Benefit:** 75% = $179.10 85% = $203.00 |

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| 47765 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.)<br>**Fee:** $392.10 **Benefit:** 75% = $294.10 |
| 47768 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)<br>**Fee:** $480.35 **Benefit:** 75% = $360.30 |
| 47771 | ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)<br>**Fee:** $551.85 **Benefit:** 75% = $413.90 |
| 47774 | MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.)<br>**Fee:** $435.65 **Benefit:** 75% = $326.75 |
| 47777 | MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)<br>**Fee:** $435.65 **Benefit:** 75% = $326.75 |
| 47780 | MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)<br>**Fee:** $566.35 **Benefit:** 75% = $424.80 |
| 47783 | MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.)<br>**Fee:** $566.35 **Benefit:** 75% = $424.80 85% = $491.85 |
| 47786 | MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)<br>**Fee:** $718.75 **Benefit:** 75% = $539.10 |
| 47789 | MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)<br>**Fee:** $718.75 **Benefit:** 75% = $539.10 |
| | *GENERAL* |
| 47900 | BONE CYST, injection into or aspiration of (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47903 | EPICONDYLITIS, open operation for (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47904 | DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.)<br>**Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05 |
| 47906 | DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |
| 47912 | PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.)<br>**Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05 |
| 47915 | INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 47916 | 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.)<br>**Fee:** $85.15 **Benefit:** 75% = $63.90 85% = $72.40 |
| 47918 | INGROWING TOENAIL, radical excision of nailbed (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 47920 | BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)<br>**Fee:** $380.80 **Benefit:** 75% = $285.60 |
| 47921 | ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)<br>**Fee:** $112.85 **Benefit:** 75% = $84.65 85% = $95.95 |

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| 47924 | 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.)<br>**Fee:** $37.65 **Benefit:** 75% = $28.25 85% = $32.05 |
| 47927 | 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.)<br>**Fee:** $141.25 **Benefit:** 75% = $105.95 |
| 47930 | PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 |
| 47933 | SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision of, or simple removal of bunion and any associated bursa, not being a service associated with a service for removal of bursa (Anaes.)<br>*(See para T8.114 of explanatory notes to this Category)*<br>**Fee:** $207.00 **Benefit:** 75% = $155.25 85% = $175.95 |
| 47936 | LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Anaes.) (Assist.)<br>*(See para T8.114 of explanatory notes to this Category)*<br>**Fee:** $254.20 **Benefit:** 75% = $190.65 |
| 47948 | EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.)<br>**Fee:** $160.05 **Benefit:** 75% = $120.05 |
| 47951 | EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.)<br>**Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00 |
| 47954 | TENDON, repair of, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 85% = $320.10 |
| 47957 | TENDON, large, lengthening of, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 |
| 47960 | TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.)<br>**Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10 |
| 47963 | TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.)<br>**Fee:** $216.50 **Benefit:** 75% = $162.40 85% = $184.05 |
| 47966 | TENDON OR LIGAMENT, TRANSFER, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 |
| 47969 | TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 |
| 47972 | TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.)<br>**Fee:** $210.60 **Benefit:** 75% = $157.95 |
| 47975 | FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.)<br>**Fee:** $369.15 **Benefit:** 75% = $276.90 |
| 47978 | FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.)<br>**Fee:** $224.20 **Benefit:** 75% = $168.15 |
| 47981 | FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.)<br>**Fee:** $150.55 **Benefit:** 75% = $112.95 85% = $128.00 |
| 47982 | FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.)<br>**Fee:** $364.90 **Benefit:** 75% = $273.70 |

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| | *BONE GRAFTS* |
| 48200 | FEMUR, bone graft to (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 48203 | FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.)<br>**Fee:** $913.25 **Benefit:** 75% = $684.95 |
| 48206 | TIBIA, bone graft to (Anaes.) (Assist.)<br>**Fee:** $565.45 **Benefit:** 75% = $424.10 |
| 48209 | TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.)<br>**Fee:** $724.95 **Benefit:** 75% = $543.75 |
| 48212 | HUMERUS, bone graft to (Anaes.) (Assist.)<br>**Fee:** $565.45 **Benefit:** 75% = $424.10 |
| 48215 | HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.)<br>**Fee:** $724.95 **Benefit:** 75% = $543.75 |
| 48218 | RADIUS AND ULNA, bone graft to (Anaes.) (Assist.)<br>**Fee:** $565.45 **Benefit:** 75% = $424.10 |
| 48221 | RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 48224 | RADIUS OR ULNA, bone graft to (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 48227 | RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)<br>**Fee:** $489.55 **Benefit:** 75% = $367.20 |
| 48230 | SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.)<br>**Fee:** $423.75 **Benefit:** 75% = $317.85 |
| 48233 | SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| 48236 | SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.)<br>**Fee:** $800.20 **Benefit:** 75% = $600.15 |
| 48239 | BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $442.45 **Benefit:** 75% = $331.85 |
| 48242 | BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| | *OSTEOTOMY AND OSTEECTOMY* |
| 48400 | PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 48403 | PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $517.80 **Benefit:** 75% = $388.35 |
| 48406 | FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 48409 | FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $517.80 **Benefit:** 75% = $388.35 |
| 48412 | HUMERUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $630.65 **Benefit:** 75% = $473.00 |

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| 48415 | HUMERUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $800.20 **Benefit:** 75% = $600.15 |
| 48418 | TIBIA, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $630.65 **Benefit:** 75% = $473.00 |
| 48421 | TIBIA, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $800.20 **Benefit:** 75% = $600.15 |
| 48424 | FEMUR OR PELVIS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 48427 | FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)<br>**Fee:** $913.25 **Benefit:** 75% = $684.95 |
| | *EPIPHYSEODESIS* |
| 48500 | FEMUR, epiphysiodesis of (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 48503 | TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 48506 | FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)<br>**Fee:** $489.55 **Benefit:** 75% = $367.20 |
| 48509 | EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.)<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 |
| 48512 | EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.)<br>**Fee:** $894.40 **Benefit:** 75% = $670.80 |
| | *SPINE* |
| 48600 | SPINE, MANIPULATION OF, performed in the operating theatre of a hospital (Anaes.)<br>**Fee:** $94.00 **Benefit:** 75% = $70.50 |
| 48603 | SPINE, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital, not being a service associated with a service to which item 48600 or 50115 applies (Anaes.)<br>**Fee:** $141.25 **Benefit:** 75% = $105.95 85% = $120.10 |
| 48606 | SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes.) (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 48612 | SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.) (Assist.)<br>**Fee:** $2,447.85 **Benefit:** 75% = $1,835.90 |
| 48613 | SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.)<br>**Fee:** $3,481.80 **Benefit:** 75% = $2,611.35 |
| 48615 | SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.) (Assist.)<br>**Fee:** $442.45 **Benefit:** 75% = $331.85 |
| 48618 | SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.) (Assist.)<br>**Fee:** $2,447.85 **Benefit:** 75% = $1,835.90 |
| 48621 | SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.) (Assist.)<br>**Fee:** $1,600.65 **Benefit:** 75% = $1,200.50 |

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| 48624 | SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.)<br>**Fee:** $1,977.20 **Benefit:** 75% = $1,482.90 |
| 48627 | SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.) (Assist.)<br>**Fee:** $2,541.85 **Benefit:** 75% = $1,906.40 |
| 48630 | SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Anaes.) (Assist.)<br>**Fee:** $2,824.35 **Benefit:** 75% = $2,118.30 |
| 48632 | SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes.) (Assist.)<br>**Fee:** $1,561.30 **Benefit:** 75% = $1,171.00 |
| 48636 | PERCUTANEOUS LUMBAR PARTIAL OR TOTAL DISCECTOMY, 1 or more levels, not being a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.)<br>*(See para T8.115 of explanatory notes to this Category)*<br>**Fee:** $809.55 **Benefit:** 75% = $607.20 85% = $735.05 |
| 48639 | VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.) (Assist.)<br>**Fee:** $1,365.00 **Benefit:** 75% = $1,023.75 |
| 48640 | VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.)<br>**Fee:** $3,481.80 **Benefit:** 75% = $2,611.35 |
| 48642 | SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.) (Assist.)<br>**Fee:** $800.20 **Benefit:** 75% = $600.15 |
| 48645 | SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 48648 | SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 48651 | SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.) (Assist.)<br>**Fee:** $1,506.45 **Benefit:** 75% = $1,129.85 |
| 48654 | SPINAL FUSION (posterior interbody), with partial or total laminectomy, 1 level (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 48657 | SPINAL FUSION (posterior interbody), with partial or total laminectomy, more than 1 level (Anaes.) (Assist.)<br>**Fee:** $1,506.45 **Benefit:** 75% = $1,129.85 |
| 48660 | SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.)<br>*(See para T8.116 of explanatory notes to this Category)*<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 48663 | SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.)<br>*(See para T8.116 of explanatory notes to this Category)*<br>**Fee:** $809.55 **Benefit:** 75% = $607.20 |
| 48666 | SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.)<br>*(See para T8.116 of explanatory notes to this Category)*<br>**Fee:** $489.55 **Benefit:** 75% = $367.20 |
| 48669 | SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.)<br>*(See para T8.116 of explanatory notes to this Category)*<br>**Fee:** $1,459.20 **Benefit:** 75% = $1,094.40 |

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| 48672 | SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.)<br>*(See para T8.116 of explanatory notes to this Category)*<br>**Fee:** $1,092.25 **Benefit:** 75% = $819.20 |
| 48675 | SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.)<br>*(See para T8.116 of explanatory notes to this Category)*<br>**Fee:** $659.15 **Benefit:** 75% = $494.40 |
| 48678 | SPINE, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes.) (Assist.)<br>*(See para T8.117 of explanatory notes to this Category)*<br>**Fee:** $565.45 **Benefit:** 75% = $424.10 |
| 48681 | SPINE, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Anaes.) (Assist.)<br>*(See para T8.117 of explanatory notes to this Category)*<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 48684 | SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.)<br>*(See para T8.117 of explanatory notes to this Category)*<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 48687 | SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Anaes.) (Assist.)<br>*(See para T8.117 of explanatory notes to this Category)*<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 48690 | SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Anaes.) (Assist.)<br>*(See para T8.117 of explanatory notes to this Category)*<br>**Fee:** $1,506.45 **Benefit:** 75% = $1,129.85 |
| 48691 | LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (Anaes.) (Assist.)<br>**Fee:** $1,793.65 **Benefit:** 75% = $1,345.25 85% = $1,719.15 |
| 48692 | LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.)<br>**Fee:** $1,208.95 **Benefit:** 75% = $906.75 85% = $1,134.45 |
| 48693 | LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, (where an assisting surgeon performs the approach) - assisting surgeon (Anaes.) (Assist.)<br>**Fee:** $584.70 **Benefit:** 75% = $438.55 85% = $510.20 |
| 48694 | Cervical artificial intervertebral total disc replacement, at one level only, including removal of disc, for a patient who:<br>(a) has not had prior spinal surgery at the same cervical level; and<br>(b) is skeletally mature; and<br>(c) has symptomatic degenerative disc disease with radiculopathy; and<br>(d) does not have vertebral osteoporosis; and<br>(e) has failed conservative therapy;<br>other than a service associated with item 40300 or 40301 (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| | *SHOULDER* |
| 48900 | SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 85% = $240.00 |

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| 48903 | SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.)<br>**Fee:** $564.85 **Benefit:** 75% = $423.65 |
| 48906 | SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.) (Assist.)<br>**Fee:** $564.85 **Benefit:** 75% = $423.65 |
| 48909 | SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 48912 | SHOULDER, arthrotomy of (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 85% = $280.20 |
| 48915 | SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 48918 | SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.)<br>**Fee:** $1,506.45 **Benefit:** 75% = $1,129.85 |
| 48921 | SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.)<br>**Fee:** $1,553.40 **Benefit:** 75% = $1,165.05 |
| 48924 | SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.)<br>**Fee:** $1,788.85 **Benefit:** 75% = $1,341.65 |
| 48927 | SHOULDER prosthesis, removal of (Anaes.) (Assist.)<br>**Fee:** $367.05 **Benefit:** 75% = $275.30 |
| 48930 | SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 48933 | SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.)<br>**Fee:** $988.55 **Benefit:** 75% = $741.45 |
| 48936 | SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 48939 | SHOULDER, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 48942 | SHOULDER, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.)<br>**Fee:** $1,412.20 **Benefit:** 75% = $1,059.15 |
| 48945 | SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 |
| 48948 | SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| 48951 | SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)<br>**Fee:** $894.40 **Benefit:** 75% = $670.80 |
| 48954 | SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |

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| 48957 | SHOULDER, arthroscopic 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 (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 48960 | SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| | *ELBOW* |
| 49100 | ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 49103 | ELBOW, ligamentous stabilisation of (Anaes.) (Assist.)<br>**Fee:** $706.05 **Benefit:** 75% = $529.55 |
| 49106 | ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 85% = $866.95 |
| 49109 | ELBOW, total synovectomy of (Anaes.) (Assist.)<br>**Fee:** $706.05 **Benefit:** 75% = $529.55 |
| 49112 | ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.)<br>**Fee:** $706.05 **Benefit:** 75% = $529.55 |
| 49115 | ELBOW, total joint replacement of (Anaes.) (Assist.)<br>**Fee:** $1,129.65 **Benefit:** 75% = $847.25 |
| 49116 | ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,491.15 **Benefit:** 75% = $1,118.40 |
| 49117 | ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,789.35 **Benefit:** 75% = $1,342.05 |
| 49118 | ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 |
| 49121 | ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| | *WRIST* |
| 49200 | WRIST, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $818.95 **Benefit:** 75% = $614.25 |
| 49203 | WRIST, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| 49206 | WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $564.85 **Benefit:** 75% = $423.65 |
| 49209 | WRIST, total replacement arthroplasty of (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 49210 | WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $994.30 **Benefit:** 75% = $745.75 |

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| 49211 | WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,193.15 **Benefit:** 75% = $894.90 |
| 49212 | WRIST, arthrotomy of (Anaes.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 |
| 49215 | WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $649.70 **Benefit:** 75% = $487.30 |
| 49218 | WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 |
| 49221 | WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| 49224 | WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy, not being a service associated with any other arthroscopic procedure of the wrist (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $706.05 **Benefit:** 75% = $529.55 |
| 49227 | WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.)<br>*(See para T8.118 of explanatory notes to this Category)*<br>**Fee:** $706.05 **Benefit:** 75% = $529.55 |
| | *HIP* |
| 49300 | SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.)<br>**Fee:** $521.25 **Benefit:** 75% = $390.95 |
| 49303 | HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.) (Assist.)<br>**Fee:** $546.00 **Benefit:** 75% = $409.50 |
| 49306 | HIP arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 49309 | HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement )) (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 49312 | HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 49315 | HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.)<br>**Fee:** $847.35 **Benefit:** 75% = $635.55 |
| 49318 | HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 49319 | HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.)<br>**Fee:** $2,315.30 **Benefit:** 75% = $1,736.50 |
| 49321 | HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.)<br>**Fee:** $1,600.65 **Benefit:** 75% = $1,200.50 |
| 49324 | HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,882.95 **Benefit:** 75% = $1,412.25 |

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| 49327 | HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.)<br>**Fee:** $2,165.35 **Benefit:** 75% = $1,624.05 |
| 49330 | HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.)<br>**Fee:** $2,165.35 **Benefit:** 75% = $1,624.05 |
| 49333 | HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.)<br>**Fee:** $2,447.85 **Benefit:** 75% = $1,835.90 |
| 49336 | HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.)<br>**Fee:** $357.70 **Benefit:** 75% = $268.30 |
| 49339 | HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.)<br>**Fee:** $2,777.30 **Benefit:** 75% = $2,083.00 |
| 49342 | HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.)<br>**Fee:** $2,777.30 **Benefit:** 75% = $2,083.00 |
| 49345 | HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.)<br>**Fee:** $3,295.10 **Benefit:** 75% = $2,471.35 |
| 49346 | HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.)<br>**Fee:** $847.35 **Benefit:** 75% = $635.55 |
| 49360 | HIP, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.)<br>**Fee:** $343.95 **Benefit:** 75% = $258.00 |
| 49363 | HIP, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.)<br>**Fee:** $414.20 **Benefit:** 75% = $310.65 85% = $352.10 |
| 49366 | HIP, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| | *KNEE* |
| 49500 | KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 49503 | 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 (not being a service to which another item in this Group applies) – any 1 procedure (Anaes.) (Assist.)<br>**Fee:** $489.55 **Benefit:** 75% = $367.20 |
| 49506 | 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 (not being a service to which another item in this Group applies) – any 2 or more procedures (Anaes.) (Assist.)<br>**Fee:** $734.40 **Benefit:** 75% = $550.80 |
| 49509 | KNEE, total synovectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 49512 | KNEE, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,082.70 **Benefit:** 75% = $812.05 |
| 49515 | KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.)<br>**Fee:** $847.35 **Benefit:** 75% = $635.55 |

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| 49517 | KNEE, hemiarthroplasty of (Anaes.) (Assist.)<br>**Fee:** $1,206.35 **Benefit:** 75% = $904.80 |
| 49518 | KNEE, total replacement arthroplasty of (Anaes.) (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 49519 | KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.)<br>**Fee:** $2,315.30 **Benefit:** 75% = $1,736.50 |
| 49521 | KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.)<br>**Fee:** $1,600.65 **Benefit:** 75% = $1,200.50 |
| 49524 | KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.)<br>**Fee:** $1,882.95 **Benefit:** 75% = $1,412.25 |
| 49527 | KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,600.65 **Benefit:** 75% = $1,200.50 |
| 49530 | KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,977.20 **Benefit:** 75% = $1,482.90 |
| 49533 | KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $2,259.65 **Benefit:** 75% = $1,694.75 |
| 49534 | KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.)<br>**Fee:** $449.55 **Benefit:** 75% = $337.20 |
| 49536 | 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.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 49539 | 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 to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 49542 | KNEE, reconstructive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 49545 | KNEE, revision arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 49548 | KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.)<br>**Fee:** $941.45 **Benefit:** 75% = $706.10 |
| 49551 | KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.)<br>**Fee:** $1,317.80 **Benefit:** 75% = $988.35 |
| 49554 | KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.)<br>**Fee:** $1,882.95 **Benefit:** 75% = $1,412.25 |
| 49557 | KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.)<br>*(See para T8.119 of explanatory notes to this Category)*<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 |
| 49558 | KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 |

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| 49559 | KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)<br>**Fee:** $408.70 **Benefit:** 75% = $306.55 |
| 49560 | KNEE, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release – not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)<br>**Fee:** $551.60 **Benefit:** 75% = $413.70 |
| 49561 | KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty – not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)<br>**Fee:** $674.00 **Benefit:** 75% = $505.50 |
| 49562 | KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty – not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)<br>**Fee:** $735.50 **Benefit:** 75% = $551.65 |
| 49563 | KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft (excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation) –not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)<br>*(See para T8.119 of explanatory notes to this Category)*<br>**Fee:** $796.70 **Benefit:** 75% = $597.55 |
| 49564 | KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)<br>**Fee:** $919.05 **Benefit:** 75% = $689.30 |
| 49566 | KNEE, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 49569 | KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| | *ANKLE* |
| 49700 | ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 |
| 49703 | ANKLE, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| 49706 | ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 49709 | ANKLE, ligamentous stabilisation of (Anaes.) (Assist.)<br>**Fee:** $706.05 **Benefit:** 75% = $529.55 |
| 49712 | ANKLE, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 49715 | ANKLE, total joint replacement of (Anaes.) (Assist.)<br>**Fee:** $1,129.65 **Benefit:** 75% = $847.25 |
| 49716 | ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,491.15 **Benefit:** 75% = $1,118.40 |
| 49717 | ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.)<br>**Fee:** $1,789.35 **Benefit:** 75% = $1,342.05 |
| 49718 | ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |

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| 49721 | ANKLE, Achilles' tendon rupture managed by non-operative treatment<br>**Fee:** $235.50 **Benefit:** 75% = $176.65 85% = $200.20 |
| 49724 | ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.)<br>**Fee:** $659.15 **Benefit:** 75% = $494.40 |
| 49727 | ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 |
| 49728 | ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.)<br>**Fee:** $564.70 **Benefit:** 75% = $423.55 |
| | *FOOT* |
| 49800 | FOOT, flexor or extensor tendon, primary repair of (Anaes.)<br>**Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10 |
| 49803 | FOOT, flexor or extensor tendon, secondary repair of (Anaes.)<br>**Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10 |
| 49806 | FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.)<br>**Fee:** $131.85 **Benefit:** 75% = $98.90 85% = $112.10 |
| 49809 | FOOT, open tenotomy of, with or without tenoplasty (Anaes.)<br>**Fee:** $216.50 **Benefit:** 75% = $162.40 |
| 49812 | FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 |
| 49815 | FOOT, triple arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 49818 | FOOT, excision of calcaneal spur (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 |
| 49821 | FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 |
| 49824 | FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.)<br>**Fee:** $757.95 **Benefit:** 75% = $568.50 |
| 49827 | FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 |
| 49830 | FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.)<br>**Fee:** $823.75 **Benefit:** 75% = $617.85 |
| 49833 | FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.)<br>**Fee:** $517.80 **Benefit:** 75% = $388.35 |
| 49836 | FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.)<br>**Fee:** $894.40 **Benefit:** 75% = $670.80 |
| 49837 | 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.)<br>**Fee:** $647.25 **Benefit:** 75% = $485.45 |
| 49838 | 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 - bilateral (Anaes.) (Assist.)<br>**Fee:** $1,117.75 **Benefit:** 75% = $838.35 |

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| 49839 | FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.)<br>**Fee:** $517.80 **Benefit:** 75% = $388.35 |
| 49842 | FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.)<br>**Fee:** $894.40 **Benefit:** 75% = $670.80 |
| 49845 | FOOT, arthrodesis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 |
| 49848 | FOOT, correction of claw or hammer toe (Anaes.)<br>**Fee:** $160.05 **Benefit:** 75% = $120.05 85% = $136.05 |
| 49851 | FOOT, correction of claw or hammer toe with internal fixation (Anaes.)<br>**Fee:** $207.00 **Benefit:** 75% = $155.25 |
| 49854 | FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.)<br>**Fee:** $376.55 **Benefit:** 75% = $282.45 |
| 49857 | FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.)<br>**Fee:** $348.35 **Benefit:** 75% = $261.30 |
| 49860 | FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)<br>**Fee:** $282.35 **Benefit:** 75% = $211.80 |
| 49863 | FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)<br>**Fee:** $423.75 **Benefit:** 75% = $317.85 |
| 49866 | FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)<br>**Fee:** $301.05 **Benefit:** 75% = $225.80 |
| 49878 | TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.)<br>**Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05 |
| | *OTHER JOINTS* |
| 50100 | JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.)<br>**Fee:** $272.95 **Benefit:** 75% = $204.75 85% = $232.05 |
| 50102 | JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| 50103 | JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $329.60 **Benefit:** 75% = $247.20 |
| 50104 | JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $312.30 **Benefit:** 75% = $234.25 85% = $265.50 |
| 50106 | JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 |
| 50109 | JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $470.70 **Benefit:** 75% = $353.05 |
| 50112 | CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $361.05 **Benefit:** 75% = $270.80 |
| 50115 | JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.)<br>**Fee:** $142.95 **Benefit:** 75% = $107.25 85% = $121.55 |
| 50118 | SUBTALAR JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $432.95 **Benefit:** 75% = $324.75 |

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| 50121 | GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.)<br>**Fee:** $847.35 **Benefit:** 75% = $635.55 |
| 50127 | JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.)<br>**Fee:** $702.50 **Benefit:** 75% = $526.90 |
| 50130 | JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)<br>**Fee:** $312.30 **Benefit:** 75% = $234.25 |
| | *MALIGNANT DISEASE* |
| 50200 | AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.)<br>**Fee:** $188.20 **Benefit:** 75% = $141.15 85% = $160.00 |
| 50201 | AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.)<br>**Fee:** $329.50 **Benefit:** 75% = $247.15 |
| 50203 | BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.)<br>**Fee:** $414.25 **Benefit:** 75% = $310.70 85% = $352.15 |
| 50206 | BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)<br>**Fee:** $611.90 **Benefit:** 75% = $458.95 |
| 50209 | BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.)<br>**Fee:** $753.25 **Benefit:** 75% = $564.95 |
| 50212 | MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.) (Assist.)<br>**Fee:** $1,647.55 **Benefit:** 75% = $1,235.70 |
| 50215 | MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.)<br>**Fee:** $2,071.20 **Benefit:** 75% = $1,553.40 |
| 50218 | MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Anaes.) (Assist.)<br>**Fee:** $2,730.30 **Benefit:** 75% = $2,047.75 |
| 50221 | MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.)<br>**Fee:** $2,541.85 **Benefit:** 75% = $1,906.40 |
| 50224 | MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.)<br>**Fee:** $2,824.35 **Benefit:** 75% = $2,118.30 85% = $2,749.85 |
| 50227 | MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.)<br>**Fee:** $3,295.10 **Benefit:** 75% = $2,471.35 |
| 50230 | BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.)<br>**Fee:** $1,694.60 **Benefit:** 75% = $1,270.95 |
| 50233 | MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.)<br>**Fee:** $2,165.35 **Benefit:** 75% = $1,624.05 |
| 50236 | MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.)<br>**Fee:** $1,694.60 **Benefit:** 75% = $1,270.95 |
| 50239 | MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.)<br>**Fee:** $1,129.65 **Benefit:** 75% = $847.25 |

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| | *LIMB LENGTHENING AND DEFORMITY CORRECTION* |
| 50300 | JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.)<br>**Fee:** $1,157.70 **Benefit:** 75% = $868.30 |
| 50303 | 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.)<br>**Fee:** $1,580.60 **Benefit:** 75% = $1,185.45 |
| 50306 | LIMB LENGTHENING , where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Anaes.) (Assist.)<br>**Fee:** $2,467.90 **Benefit:** 75% = $1,850.95 85% = $2,393.40 |
| 50309 | RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.)<br>**Fee:** $305.05 **Benefit:** 75% = $228.80 |
| 50312 | ANKLE, synovectomy of, by arthroscopic or open means - not associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.)<br>**Fee:** $700.10 **Benefit:** 75% = $525.10 |
| 50315 | TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.)<br>**Fee:** $693.30 **Benefit:** 75% = $520.00 |
| 50318 | TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.)<br>**Fee:** $693.30 **Benefit:** 75% = $520.00 |
| 50321 | TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.)<br>**Fee:** $928.85 **Benefit:** 75% = $696.65 |
| 50324 | TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.)<br>**Fee:** $1,324.15 **Benefit:** 75% = $993.15 |
| 50327 | TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.)<br>**Fee:** $1,615.15 **Benefit:** 75% = $1,211.40 |
| 50330 | TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.)<br>**Fee:** $228.70 **Benefit:** 75% = $171.55 85% = $194.40 |
| 50333 | TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.)<br>**Fee:** $616.85 **Benefit:** 75% = $462.65 |
| 50336 | TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.)<br>**Fee:** $922.05 **Benefit:** 75% = $691.55 |
| 50339 | FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.)<br>**Fee:** $561.55 **Benefit:** 75% = $421.20 |
| 50342 | FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.)<br>**Fee:** $651.60 **Benefit:** 75% = $488.70 |
| 50345 | HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.)<br>**Fee:** $346.65 **Benefit:** 75% = $260.00 |
| | ***HIP, KNEE AND LEG PROCEDURES*** |
| 50348 | KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.)<br>**Fee:** $228.70 **Benefit:** 75% = $171.55 85% = $194.40 |

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| 50349 | HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.)<br>**Fee:** $320.15 **Benefit:** 75% = $240.15 85% = $272.15 |
| 50351 | HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.)<br>**Fee:** $1,597.25 **Benefit:** 75% = $1,197.95 |
| 50352 | HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.)<br>**Fee:** $56.50 **Benefit:** 75% = $42.40 85% = $48.05 |
| 50353 | HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.)<br>**Fee:** $354.80 **Benefit:** 75% = $266.10 |
| 50354 | TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.)<br>**Fee:** $1,310.15 **Benefit:** 75% = $982.65 85% = $1,235.65 |
| 50357 | KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.)<br>**Fee:** $561.55 **Benefit:** 75% = $421.20 |
| 50360 | KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.)<br>**Fee:** $651.60 **Benefit:** 75% = $488.70 |
| 50363 | KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.)<br>**Fee:** $499.05 **Benefit:** 75% = $374.30 |
| 50366 | KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.)<br>**Fee:** $873.45 **Benefit:** 75% = $655.10 |
| 50369 | KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.)<br>**Fee:** $651.60 **Benefit:** 75% = $488.70 |
| 50372 | KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.)<br>**Fee:** $1,143.80 **Benefit:** 75% = $857.85 |
| 50375 | HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.)<br>**Fee:** $499.05 **Benefit:** 75% = $374.30 |
| 50378 | HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.) (Assist.)<br>**Fee:** $873.45 **Benefit:** 75% = $655.10 |
| 50381 | HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.) (Assist.)<br>**Fee:** $651.60 **Benefit:** 75% = $488.70 |
| 50384 | 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.)<br>**Fee:** $1,143.80 **Benefit:** 75% = $857.85 |
| 50387 | HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.)<br>**Fee:** $651.60 **Benefit:** 75% = $488.70 |
| 50390 | PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.)<br>**Fee:** $228.70 **Benefit:** 75% = $171.55 85% = $194.40 |
| 50393 | PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.)<br>**Fee:** $845.60 **Benefit:** 75% = $634.20 |
| 50394 | ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.)<br>**Fee:** $2,777.30 **Benefit:** 75% = $2,083.00 |

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| | ***SHOULDER, ARM AND FOREARM PROCEDURES*** |
| 50396 | HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.)<br>**Fee:** $464.55 **Benefit:** 75% = $348.45 |
| 50399 | FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.)<br>**Fee:** $922.05 **Benefit:** 75% = $691.55 |
| 50402 | TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.)<br>**Fee:** $422.95 **Benefit:** 75% = $317.25 |
| 50405 | ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.)<br>**Fee:** $575.40 **Benefit:** 75% = $431.55 |
| 50408 | SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.)<br>**Fee:** $998.25 **Benefit:** 75% = $748.70 |
| | ***AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES*** |
| 50411 | LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.)<br>**Fee:** $1,310.15 **Benefit:** 75% = $982.65 85% = $1,235.65 |
| 50414 | LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.)<br>**Fee:** $1,767.60 **Benefit:** 75% = $1,325.70 85% = $1,693.10 |
| 50417 | LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.)<br>**Fee:** $1,310.15 **Benefit:** 75% = $982.65 85% = $1,235.65 |
| 50420 | PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.)<br>**Fee:** $1,081.35 **Benefit:** 75% = $811.05 |
| 50423 | TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.)<br>**Fee:** $998.25 **Benefit:** 75% = $748.70 85% = $923.75 |
| | ***TUMOROUS CONDITIONS*** |
| 50426 | DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.)<br>**Fee:** $464.55 **Benefit:** 75% = $348.45 |
| | *SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY* |
| 50450 | **UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:**<br>- Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>- Correction of muscle imbalance by tendon transfer/transfers.<br>- Correction of femoral torsion by rotational osteotomy of the femur.<br>- Correction of tibial torsion by rotational osteotomy of the tibia.<br>- Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening.<br>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $1,226.90 **Benefit:** 75% = $920.20 |

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| 50451 | **UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:**<br>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>(b) Correction of muscle imbalance by tendon transfer/transfers.<br>(c) Correction of femoral torsion by rotational osteotomy of the femur.<br>(d) Correction of tibial torsion by rotational osteotomy of the tibia.<br>(e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening.<br>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $1,226.90 **Benefit:** 75% = $920.20 |
| 50455 | **BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:**<br>- Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>- Correction of muscle imbalance by tendon transfer/transfers.<br>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $1,389.40 **Benefit:** 75% = $1,042.05 |
| 50456 | **BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:**<br>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>(b) Correction of muscle imbalance by tendon transfer/transfers.<br>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $1,389.40 **Benefit:** 75% = $1,042.05 |
| 50460 | **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.**<br>- Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>- Correction of muscle imbalance by tendon transfer/transfers.<br>- Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation.<br>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $2,074.45 **Benefit:** 75% = $1,555.85 |
| 50461 | **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.**<br>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>(b) Correction of muscle imbalance by tendon transfer/transfers.<br>(c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation.<br>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $2,074.45 **Benefit:** 75% = $1,555.85 |
| 50465 | **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.**<br>- Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>- Correction of muscle imbalance by tendon transfer/transfers.<br>- Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.<br>- Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.<br>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $2,921.80 **Benefit:** 75% = $2,191.35 |

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| 50466 | **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.**<br>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>(b) Correction of muscle imbalance by tendon transfer/transfers.<br>(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.<br>(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.<br>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $2,921.80 **Benefit:** 75% = $2,191.35 |
| 50470 | **BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.**<br>- Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>- Correction of muscle imbalance by tendon transfer/transfers.<br>- Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.<br>- Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.<br>- Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion.<br>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $3,705.55 **Benefit:** 75% = $2,779.20 |
| 50471 | **BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.**<br>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>(b) Correction of muscle imbalance by tendon transfer/transfers.<br>(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.<br>(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.<br>(e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion.<br>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $3,705.55 **Benefit:** 75% = $2,779.20 |
| 50475 | **SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:**<br>- Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>- Correction of muscle imbalance by tendon transfer/transfers.<br>- Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation.<br>- Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction.<br>- Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation.<br>- Correction of foot instability by os calcis lengthening or subtalar fusion.<br>Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $4,275.85 **Benefit:** 75% = $3,206.90 |
| 50476 | **SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:**<br>(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.<br>(b) Correction of muscle imbalance by tendon transfer/transfers.<br>(c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation.<br>(d) Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction.<br>(e) Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation.<br>(f) Correction of foot instability by os calcis lengthening or subtalar fusion.<br>Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $4,275.85 **Benefit:** 75% = $3,206.90 |
| | *TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS* |
| 50500 | RADIUS OR ULNA, distal end of, ***with open growth plate***, treatment of fracture of, by closed reduction (Anaes.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $276.65 **Benefit:** 75% = $207.50 85% = $235.20 |

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| 50504 | RADIUS OR ULNA, distal end of, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $369.05 **Benefit:** 75% = $276.80 85% = $313.70 |
| 50508 | RADIUS, distal end of, ***with open growth plate***, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $395.25 **Benefit:** 75% = $296.45 85% = $336.00 |
| 50512 | RADIUS, distal end of, ***with open growth plate***, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $527.30 **Benefit:** 75% = $395.50 |
| 50516 | 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.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $355.85 **Benefit:** 75% = $266.90 85% = $302.50 |
| 50520 | RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $474.40 **Benefit:** 75% = $355.80 |
| 50524 | 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.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $408.50 **Benefit:** 75% = $306.40 85% = $347.25 |
| 50528 | 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.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $659.00 **Benefit:** 75% = $494.25 |
| 50532 | RADIUS AND ULNA, shafts of, ***with open growth plates***, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $573.40 **Benefit:** 75% = $430.05 |
| 50536 | RADIUS AND ULNA, shafts of, ***with open growth plates***, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $764.40 **Benefit:** 75% = $573.30 |
| 50540 | OLECRANON, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $527.30 **Benefit:** 75% = $395.50 |
| 50544 | RADIUS, ***with open growth plate***, treatment of fracture of head or neck of, by closed reduction of (Anaes.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10 |
| 50548 | 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.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $527.30 **Benefit:** 75% = $395.50 |
| 50552 | 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.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $454.75 **Benefit:** 75% = $341.10 85% = $386.55 |
| 50556 | HUMERUS, proximal, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $606.20 **Benefit:** 75% = $454.65 |

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| 50560 | 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.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $474.40 **Benefit:** 75% = $355.80 |
| 50564 | HUMERUS, shaft of, ***with open growth plate***, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $632.65 **Benefit:** 75% = $474.50 |
| 50568 | HUMERUS, ***with open growth plate***, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $553.60 **Benefit:** 75% = $415.20 85% = $479.10 |
| 50572 | 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.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $738.10 **Benefit:** 75% = $553.60 |
| 50576 | FEMUR, ***with open growth plate***, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $606.20 **Benefit:** 75% = $454.65 85% = $531.70 |
| 50580 | TIBIA, ***with open growth plate***, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $632.65 **Benefit:** 75% = $474.50 |
| 50584 | TIBIA, distal, ***with open growth plate,*** treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $606.20 **Benefit:** 75% = $454.65 |
| 50588 | TIBIA AND FIBULA, ***with open growth plates***, treatment of fracture of, by internal fixation (Anaes.) (Assist.)<br>*(See para T8.120 and T8.121 of explanatory notes to this Category)*<br>**Fee:** $790.70 **Benefit:** 75% = $593.05 |
| | *SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS* |
| 50600 | SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $434.70 **Benefit:** 75% = $326.05 85% = $369.50 |
| 50604 | SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $1,845.05 **Benefit:** 75% = $1,383.80 |
| 50608 | SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $3,426.95 **Benefit:** 75% = $2,570.25 |
| 50612 | 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 48642 to 48675 applies (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $4,874.50 **Benefit:** 75% = $3,655.90 |
| 50616 | SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $619.35 **Benefit:** 75% = $464.55 |
| 50620 | 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 48642 to 48675 applies (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $3,426.95 **Benefit:** 75% = $2,570.25 |

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| 50624 | 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.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $3,426.95 **Benefit:** 75% = $2,570.25 |
| 50628 | SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $4,233.20 **Benefit:** 75% = $3,174.90 |
| 50632 | 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 48642 to 48675 applies (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $3,558.65 **Benefit:** 75% = $2,669.00 |
| 50636 | 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 48642 to 48675 applies (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $3,954.10 **Benefit:** 75% = $2,965.60 |
| 50640 | 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 48642 to 48675 applies (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $2,185.80 **Benefit:** 75% = $1,639.35 |
| 50644 | SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $2,108.95 **Benefit:** 75% = $1,581.75 |
| | *TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS* |
| 50650 | HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $414.75 **Benefit:** 75% = $311.10 85% = $352.55 |
| 50654 | HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $496.65 **Benefit:** 75% = $372.50 |
| 50658 | HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.)<br>*(See para T8.120 of explanatory notes to this Category)*<br>**Fee:** $197.75 **Benefit:** 75% = $148.35 85% = $168.10 |
| | *SUBGROUP 16 - RADIOFREQUENCY ABLATION* |
| 50950 | NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by percutaneous radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50952 applies (Anaes.)<br>**Fee:** $817.10 **Benefit:** 75% = $612.85 85% = $742.60 |
| 50952 | NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by open or laparoscopic radiofrequency ablation, where a multi-disciplinary team has assessed that percutaneous radiofrequency ablation cannot be performed or is not practical because of one or more of the following clinical circumstances:<br>- percutaneous access cannot be achieved;<br>- vital organs/tissues are at risk of damage from the percutaneous RFA procedure; or<br>- resection of one part of the liver is possible however there is at least one primary liver tumour in a non-resectable region of the liver which is suitable for radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50950 applies (Anaes.)<br>*(See para T8.122 of explanatory notes to this Category)*<br>**Fee:** $817.10 **Benefit:** 75% = $612.85 85% = $742.60 |

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| | **GROUP T9 - ASSISTANCE AT OPERATIONS** |
| 51300 | 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<br>*(See para T9.1 and T9.2 of explanatory notes to this Category)*<br>**Fee:** $86.30 **Benefit:** 75% = $64.75 85% = $73.40 |
| 51303 | 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.<br>*(See para T9.1 and T9.3 of explanatory notes to this Category)*<br>**Derived Fee:** one fifth of the established fee for the operation or combination of operations |
| 51306 | Assistance at a delivery involving Caesarean section<br>*(See para T9.1 of explanatory notes to this Category)*<br>**Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00 |
| 51309 | Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section<br>*(See para T9.1 and T9.4 of explanatory notes to this Category)*<br>**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) |
| 51312 | Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633<br>*(See para T9.1 of explanatory notes to this Category)*<br>**Derived Fee:** one fifth of the established fee for the procedure or combination of procedures |
| 51315 | 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<br>*(See para T9.1 of explanatory notes to this Category)*<br>**Fee:** $272.40 **Benefit:** 75% = $204.30 85% = $231.55 |
| 51318 | Assistance at cataract and intraocular lens surgery where patient has:<br>- total loss of vision, including no potential for central vision, in the fellow eye; or<br>- previous significant surgical complication in the fellow eye; or<br>- 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<br>*(See para T9.1 and T9.5 of explanatory notes to this Category)*<br>**Fee:** $179.75 **Benefit:** 75% = $134.85 85% = $152.80 |

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