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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 <u>http://www.health.gov.au/mbsonline</u>

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GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

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

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

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

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.

GN.1.2 Medicare - an outline

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

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

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

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

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

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

GN.1.3 Medicare benefits and billing practices Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a) No Medicare benefits will be paid for the service;

(b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

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

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

GN.2.4 Provider eligibility for Medicare

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

(a) be a recognised specialist, consultant physician or general practitioner; or

(b) be in an approved placement under section 3GA of the Health Insurance Act 1973; or

(c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

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

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

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

Non-medical practitioners

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

(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and

(b) registered with the Department of Human Services to provide these services.

GN.2.5 Provider Numbers

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

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

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

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

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

GN.2.6 Locum tenens

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

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

(a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or

(b) they are associated with an approved rural placement under Section 3GA of the Health Insurance Act 1973; or

(c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or

(d) they will be at a practice which is participating in the Practice Incentives Program; or

(e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

GN.2.7 Overseas trained doctor

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

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

It is important that you contact the Department of Human Services promptly of any changes to your preferred contact details. Your preferred mailing address is used to contact you about Medicare provider matters. We require

requests for changes to your preferred contact details to be made by the provider in writing to the Department of Human Services at:

Medicare

GPO Box 9822

in your capital city

or

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

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

MBS Interpretations

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

or by phone on 132 150

GN.3.9 Patient eligibility for Medicare

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

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

GN.3.10 Medicare cards

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

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

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

GN.3.11 Visitors to Australia and temporary residents

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

GN.3.12 Reciprocal Health Care Agreements

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

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

Exceptions:

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

· Visitors from Italy and Malta are covered for a period of six months only.

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

GN.4.13 General Practice

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

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

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

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

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

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

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

Vocational recognition of general practitioners

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

- (a) certification by the RACGP that the practitioner
- \cdot is a Fellow of the RACGP; and
- · practice is, or will be within 28 days, predominantly in general practice; and

 \cdot 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

 \cdot is a Fellow of the RACGP; and

 \cdot practice is, or will be within 28, predominantly in general practice; and

 \cdot has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(c) certification by ACRRM that the practitioner

 \cdot is a Fellow of ACRRM; and

 \cdot has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

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

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

Tel: 1800 472 247 Email at: <u>qicpd@racgp.org.au</u>

Secretary, General Practice Recognition Eligibility Committee:

Email at mailto:gprec@health.gov.au

Executive Assistant, ACRRM:

Tel: (07) 3105 8200 Email at <u>acrrm@acrrm.org.au</u>

How to apply for vocational recognition

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

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

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

Continued vocational recognition is dependent upon:

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

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

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

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

Removal of vocational recognition status

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

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

· is registered as a specialist under State or Territory law; or

 \cdot holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

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

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

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

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

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

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

GN.5.15 Emergency Medicine

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

- (a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
- (b) suffering from suspected acute organ or system failure; or

(c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or

(d) suffering from a drug overdose, toxic substance or toxin effect; or

(e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or

(f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or

- (g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and
- (h) treated in, or via, a bona fide emergency department in a hospital.

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

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

What is a Referral?

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

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

(i) the referring practitioner must have undertaken a professional attendance with the patient and turned his or her mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);

(ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and

(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

(a) sub-paragraphs (i), (ii) and (iii) do not apply to

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

- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or

- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises from a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

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

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

(ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

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

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

Billing

Routine Referrals

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

- name and either practice address or provider number of the referring practitioner;

- date of referral; and

- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

Where the referral originates from a practitioner other than those listed in *Specialist Referrals*, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific 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 Department of Human Services CEO, to produce to a medical practitioner who is an employee of the Department of Human Services, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

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

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

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

Self Referral

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

GN.7.17 Billing procedures

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

Bulk billing

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

- any consumables that would be reasonably necessary to perform the service, including bandages and/or dressings;
- record keeping fees;

- a booking fee to be paid before each service, or;
- an annual administration or registration fee.

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

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

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

GN.8.18 Provision for review of individual health professionals

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence;

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

the characteristics of the patients.

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

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

Additional Information

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

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

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

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

(iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

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

GN.8.19 Medicare Participation Review Committee

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

(a) has been successfully prosecuted for relevant criminal offences;

(b) has breached an Approved Pathology Practitioner undertaking;

(c) has engaged in prohibited diagnostic imaging practices; or

(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

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

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

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

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

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

GN.8.21 Comprehensive Management Framework for the MBS

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

GN.8.22 Medical Services Advisory Committee

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

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

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

GN.8.23 Pathology Services Table Committee

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

GN.8.24 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, 30176, 30214, 35534, 32501, 42783, 42786, 42789, 42792, 45019, 45020, 45051, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639.

Claims for benefits for these services 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 to:

The MCRP Officer

PO Box 9822

SYDNEY NSW 2001

GN.9.25 Penalties and Liabilities

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

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

GN.10.26 Schedule fees and Medicare benefits

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

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.

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

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

There are presently three levels of Medicare benefit payable:

- a. 75% of the Schedule fee:
 - i. for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';
 - 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 \$81.70 (indexed annually in November), whichever is the greater, for all other professional services.

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

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

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

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

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

GN.10.27 Medicare safety nets

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

Original Medicare Safety Net:

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

Extended Medicare Safety Net:

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

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

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

Individuals are automatically registered with the Department of Human Services for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets.

In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed online at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

EMSN Benefit Caps:

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

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

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

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

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

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

GN.11.28 Services not listed in the MBS

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

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

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

The Health 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.

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

GN.12.31 Services rendered on behalf of medical practitioners

Medical services in Categories 2 and 3 not included in G.12.1 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. the Department of Human Services 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.

GN.12.32 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.

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

- (a) telephone consultations;
- (b) issue of repeat prescriptions when the patient does not attend the surgery in person;
- (c) group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);
- (d) non-therapeutic cosmetic surgery;

(e) euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract benefits.

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

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

(b) are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

(a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

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

(c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or

(d) the service is a health screening service.

(e) the service is a pre-employment screening service

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

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;

- (b) the injection of human chorionic gonadotrophin in the management of obesity;
- (c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- (d) the removal of tattoos;

(e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;

(f) the removal from a cadaver of kidneys for transplantation;

(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

- (a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;
- (b) gamma knife surgery;
- (c) intradiscal electro thermal arthroplasty;
- (d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
- (e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
- (f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
- (g) lung volume reduction surgery, for advanced emphysema;
- (h) photodynamic therapy, for skin and mucosal cancer;
- (i) placement of artificial bowel sphincters, in the management of faecal incontinence;

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

- (k) specific mass measurement of bone alkaline phosphatase;
- (1) transmyocardial laser revascularisation;
- (m) vertebral axial decompression therapy, for chronic back pain.
- (n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation.
- (o) vertebroplasty

Health Screening Services

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

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

(g) compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

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

(a) a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person (see General Explanatory note 12.3 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;

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

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

(d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

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

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

(g) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

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

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

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

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

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

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

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

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

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

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

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

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

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

Note 3: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

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

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

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

(a) a spouse, in relation to a dependant person means:

a. a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and

b. a de facto spouse of that person.

(b) a child, in relation to a dependant person means:

a. a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and

b. a person who:

(i) has attained the age of 16 years who is in the custody, care and control of the person of the spouse of the person; or

(ii) is receiving full time education at a school, college or university; and

(iii) is not being paid a disability support pension under the Social Security Act 1991; and

(iv) is wholly or substantially dependent on the person or on the spouse of the person.

GN.14.34 Principles of interpretation of the MBS

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

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

GN.14.35 Services attracting benefits on an attendance basis

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

GN.14.36 Consultation and procedures rendered at the one attendance

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

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

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

GN.14.37 Aggregate items

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

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

GN.14.38 Residential aged care facility

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

GN.15.39 Practitioners should maintain adequate and contemporaneous records

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

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

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

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

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

clearly identify the name of the patient; and

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

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

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

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

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

CATEGORY 3: THERAPEUTIC PROCEDURES

SUMMARY OF CHANGES FROM 01/05/2018

The 01/05/2018 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

	(a) new item	New
	(b) amended description	Amend
	(c) fee amended	Fee
	(d) item number change	d Renum
(e) EMSN changed		EMSN
New It		
22520	27570 20700 17657	

32528 32529 38288 42652

Description Amended

15565	30481	30482	30483	32520	32522	32523	32526	34103
15505	50101	20102	50105	51510	52522	51515	52520	51105

New Note

TN.8.136

Note Amended

TN.8.2 TN.8.33 IN.0.13 IN.0.18

Amendment to item 15565 for preparation of an intensity modulated radiotherapy (IMRT) dosimetry plan

On 1 May 2018, item 15565 will be amended to reflect developments in the methodology for dosimetric checks by removing references to the use of a dosimetric phantom.

Amended descriptors for gastrostomy items 30481, 30482 and 39483

This change amends existing gastrostomy items 30481, 30482 and 30483 (for patients who require long term enteral feeding/nutrient support) to prevent the items from being claimed in association with the insertion of experimental weight loss surgical devices.

Amendments made to items 32520,32522,32523 and 32526 to include reference to cyanoacrylate embolisation

Items 32520, 32522,32523 and 32526 have been amended to include reference to the new service, cyanoacrylate embolisation for the treatment of varicose veins due to chronic venous insufficiency.

Cyanoacrylate embolisation (CAE) for the treatment of chronic varicose veins

An alternative service to radio frequency ablation (RFA) and endovenous laser therapy (ELT) services for the treatment of varicose veins due to chronic venous insufficiency.

New cardiac items for diagnosis of atrial fibrillation in patients with embolic stroke of undetermined source

A new cardiac service for the diagnosis of atrial fibrillation in patients with embolic stroke of undetermined source, involving a new item for the insertion of implantable loop recorders (ILR), and another for investigation of the inserted ILR.

Corneal Collagen Cross Linking

New MBS Item for Corneal Collagen Cross Linking

THERAPEUTIC PROCEDURES NOTES

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

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

(a) is equipped and staffed so that it is capable of providing to a patient:

(i) hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilopascal gauge pressure); and

(ii) mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment; and

(b) is under the direction of at least 1 medical practitioner who is rostered, and immediately available, to the facility during the facility's ordinary working hours if the practitioner:

(i) is a specialist with training in diving and hyperbaric medicine; or

(ii) holds a Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society; and

(c) is staffed by:

(i) at least 1 medical practitioner with training in diving and hyperbaric medicine who is present in the facility and immediately available at all times when patients are being treated at the facility; and

(ii) at least 1 registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Technicians and Nurses Association, who is present during hyperbaric oxygen therapy; and

(d) has admission and discharge policies in operation.

TN.1.2 Haemodialysis - (Items 13100 and 13103)

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

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

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

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

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies

(generally monthly);

- Feed-back of results to the home patient and his or her treating general physician;
- Adjustments to medications and dialysis therapies based upon these results;

- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant;

- Referral to, and communication with, other specialists involved in the care of the patient; and
- Being available to advise the patient or the patient's agent.

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

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

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

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

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

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

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

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

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

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

TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

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

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

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

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

TN.1.6 Peripherally Inserted Central Catheters

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

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

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

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

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

TN.1.8 Collection of Blood - (Item 13709)

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

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

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

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

- (a) is equipped and staffed so as to be capable of providing to a patient:
- (i) mechanical ventilation for a period of several days; and
- (ii) invasive cardiovascular monitoring; and
- (b) is supported by:

(i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

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

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

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

(a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:

(i) mechanical ventilation for a period of several days; and

(ii) invasive cardiovascular monitoring; and

(b) is supported by:

(i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and

(ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and

(iii)a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

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

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

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

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

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

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

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

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

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

Items 13847 and 13848

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

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

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

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

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

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

Items 13870 and 13873

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

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

Item 13876

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

Item 11600

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

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13915)

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

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

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

TN.1.14 PUVA or UVB Therapy - (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.

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

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

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

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

Items 14203 and 14206 are not payable for artificial insemination.

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

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

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

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

TN.1.19 Immunomodulating Agent - (Item 14245)

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

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

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

(1) Items 13015 to 51318 (excluding 13209 (T1) 16400 to 16500 (T4), 16590 to 16591 (T4), 17610 to 17690 (T6) and 18350 to 18373 (T11) apply to a medical service provided by;

- (a) A medical practitioner, or;
- (b) A specialist trainee under the direct supervision of a medical practitioner.

(2) For paragraph (1) (b), a medical service provided by a specialist trainee is taken to have been provided by the supervising medical practitioner.

(3) In this rule: Specialist trainee means a medical practitioner who is undertaking an Australian Medical Council (AMC) accredited Medical College Training Program. Direct Supervision means personal and continuous attendance for the duration of the service.

TN.1.21 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

TN.2.1 Radiation Oncology - General

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

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

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

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

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

In items 15275, 15555, 15565 and 15715:

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

In item 15275:

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

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

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

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

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

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

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

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

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

It is expected that the 2D simulation items (15500, 15503, and 15506) would be used in association with the 2D planning items (15518, 15521, and 15524) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in 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 items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning items (15556, 15559, and 15562) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode. The IMRT simulation item (15555) and IMRT dosimetry item (15565) can only be billed in association with each other and only for IMRT (i.e. neither IMRT simulation item 15555, nor IMRT dosimetry item 15565, can be billed in association with any of the 2D or 3D treatment items for an episode of care).

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

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

In these items, 'treatment verification' means:

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

(a) x-rays (this includes portal imaging, either megavoltage or kilovoltage, using a linear accelerator)

(b) computed tomography; or

(c) ultrasound, where the ultrasound equipment is capable of producing images in at least three dimensions (unidimensional ultrasound is not covered); together with a record of the assessment(s) and any correction(s) of significant treatment delivery inaccuracies detected.

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

Item 15705 (multiple projections) applies where images in more that one plane are taken, for example orthogonal views to confirm the isocentre. It can be itemised only where verification is undertaken of treatments involving three or more fields. It can be itemised where single projections are acquired for multiple sites, eg multiple metastases for palliative patients. Item 15705 can be itemized only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

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

Items 15700, 15705, 15710 and 15715:

- may not claimed together for the same attendance at which treatment is rendered

- must only be itemised when the verification procedure has been prescribed in the treatment plan and the image has been reviewed by a radiation oncologist

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 16400 can only be claimed 10 times per pregnancy.

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

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

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

TN.4.3 Antenatal Care - (Item 16500)

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

(a) Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.

- (b) The initial consultation at which pregnancy is diagnosed.
- (c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
- (d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
- (e) Treatment of an intercurrent condition not directly related to the pregnancy.

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

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

Contraindications for this item are as follows:

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

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

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

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

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

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

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

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

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

TN.4.6 Caesarean Section - (Item 16520)

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

TN.4.7 Complicated Confinement - (Item 16522)

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

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

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

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

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

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

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

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

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

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

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;

(ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals

following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over <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 birth;

(iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;

(v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

Normal postnatal care by a medical practitioner would include:-

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

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

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

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

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

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

TN.4.12 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist

attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct

(ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Item 17610 (15 mins or less) - a pre-anaesthesia consultation of a straightforward nature occurring prior to investigative procedures and other routine surgery. This item covers routine pre-anaesthesia consultation services including the taking of a brief history, a limited examination of the patient including the cardio-respiratory system and brief discussion of an anaesthesia plan with the patient.

(ii) Item 17615 (16-30 mins) - a pre-anaesthesia consultation of between 16 to 30 minutes duration AND of significantly greater complexity than that required under item 17610. To qualify for benefits patients will be undergoing advanced surgery or will have complex medical problems. The consultation will involve a more extensive examination of the patient, for example: the cardio-respiratory system, the upper airway, anatomy relevant to regional anaesthesia and invasive monitoring. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

(iii) Item 17620 (31-45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and of between 31 to 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations and the formulation of an anaesthesia plan of management of which there should be a written record in the patient notes.

(iv) Item 17625 (more than 45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and item 17620 and of more than 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations as well as discussion of the patient's medical condition

and/or anaesthesia plan of management with other relevant healthcare professionals. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

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

- · Bowel resection
- · Caesarean section
- · Neonatal surgery
- · Major laparotomies
- · Radical cancer resection
- \cdot 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,

 \cdot 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

 \cdot 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:

 \cdot 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:

 \cdot Consultation services covered by pain specialists items in the range 2801-3000 cannot be claimed in conjunction with items 17610-17625

 \cdot The consultation time under items 17610 - 17625 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.

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

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

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

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

- (i) Acute pain management
- · Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)
- \cdot 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 :

 \cdot It should be noted that the consultation time under items 17640 - 17655 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.

 \cdot Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with items 17640 - 17655.

• The requirement of a written patient management plan in items 17645-17655 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

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

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

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

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

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

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

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

TN.6.4 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

TN.7.1 Regional or Field Nerve Blocks - General

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

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

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

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

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

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

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

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

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

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

This items covers caudal infusion/injection.

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

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

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

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

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

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

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

TN.8.1 Surgical Operations

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

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

An explanation of each of these phrases is as follows.

As an Independent Procedure

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

(i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;

(ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larynx or trachea;

(iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

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

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

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

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

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

TN.8.2 Multiple Operation Rule

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

- 100% for the item with the greatest Schedule fee

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

plus 25% for each other item.

Note:

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

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

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

(d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

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

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

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

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

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

Extended Medicare Safety Net Cap

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

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

TN.8.3 Procedure Performed with Local Infiltration or Digital Block

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

TN.8.4 Aftercare (Post-operative Treatment) <u>Definition</u>

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

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

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

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

Private Patients

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

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

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

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

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

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

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

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

Public Patients

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

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

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

Fractures

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

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

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

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
	6 months

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

TN.8.5 Abandoned surgery - (Item 30001)

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

An operative procedure commences when the:

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

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

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

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

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

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

For the purpose of items 30026 to 30049 the term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.

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

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

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

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

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

TN.8.8 Lipectomy - (Items 30165 to 30179)

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

For the purpose of informing patient eligibility for lipectomy items (30165-30172, 30177, 30179) that are for the management of significant weight loss (SWL), SWL is defined as a weight loss equivalent of at least five BMI units. Weight must be stable for at least six months following significant weight loss prior to lipectomy. For significant

weight loss that has occurred following pregnancy, the products of conception must not be included in the calculation of baseline weight to measure weight loss against.

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

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

Claims for benefits under lipectomy item 30176 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). Claims 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. 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**

TN.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.

TN.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 <u>Health Practitioner Guideline to substantiate proof of</u> <u>malignancy where required for MBS items</u> which is located on the DHS website.

TN.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 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

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

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

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

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

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

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

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

Anatomically, the dissection extends from below upwards as follows:

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

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

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

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

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

TN.8.16 Major Abdominal Incision - (Item 30396)

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

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

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

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

Cleaning, disinfection and sterilisation procedures

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

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

Anaesthetic and resuscitation equipment

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

Conjoint Committee

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

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

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

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

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

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

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

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

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

For the purposes of these items the following definitions apply:

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

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

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

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

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

- A patient with biochemical evidence of a neuroendocrine tumour.

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

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

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

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

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

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

histological examination. Confirmation of malignancy*must*be received before itemisation of accounts for Medicare benefits purposes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;

- Patients unable to lie prone and still for 30 to 60 minutes;
- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

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

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

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

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

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

TN.8.30 Reversal of a Bariatric Procedure - (Item 31584 and 31591)

If a revisional procedure requires the reversal of the existing bariatric procedure, item 31591 can be claimed with items 31569 to 31581 for the new procedure for the same patient on the same occasion. For example item 31591 could be claimed for reversal of gastric band, and 31572 for conversion to gastric bypass or 31575 for conversion to sleeve gastrectomy. If a revisional procedure requires the reversal of the existing bariatric procedure, item 31584 can be claimed when the service is a stand-alone procedure.

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

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

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

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

Claims for benefits under item 32501 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 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 the Department of Human Services' requirements for correct itemisation of MBS and non-MBS services on a single invoice.
- The Department of Human Services monitors billing practices associated with MBS items and any billing which stands out as being out of line with most practitioners may warrant the attention of the Department of Human Services.
- In light of the policy clarification of GMST Rule 2.44.14, with effect from 1 May 2009, the Department of Human Services will be able to track any apparent cost-shifting (of ELT and/or radiofrequency diathermy/ablation) to the MBS items detailed in GMST Rule 2.44.14 or to other MBS items.

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

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

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

TN.8.34 Uterine Artery Embolisation - (Item 35410)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.42 Colposcopic Examination - (Item 35614)

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

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

TN.8.43 Hysteroscopy - (Item 35626)

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

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

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

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

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

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

(i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a byproduct of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.

(ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.

(iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973*.

TN.8.47 Debulking of Uterus - (Item 35658)

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

TN.8.48 Nephrectomy - (Items 36526 and 36527)

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

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

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

TN.8.51 Ureteroscopy - (Item 36803)

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

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

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

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

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

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

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

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

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

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

(i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.

(ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

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

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

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

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

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

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

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

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

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

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

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

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

TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

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

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

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

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

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

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

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

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

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

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

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

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

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

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;

- electrocardiography (ECG) (items 1170-11702);
- echocardiography (items 55113-55115);
- *continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);*
- up-right tilt table test (item 11724); and

- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

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

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

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

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

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

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

TN.8.65 Cardiac Resynchronisation Therapy - (Item 38371)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TN.8.73 Meatoplasty - (Item 41515)

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

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

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

TN.8.75 Removal of Nasal Polyp or Polypi - (Items 41662, 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.

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

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

TN.8.77 Microlaryngoscopy - (Item 41858)

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

TN.8.78 Imbedded Foreign Body - (Item 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

TN.8.79 Corneal Incisions - (Item 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

TN.8.80 Cataract surgery (Items 42698 and 42701)

Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

TN.8.81 Posterior Juxtascleral Depot injection - (Item 42741)

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the

treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

TN.8.82 Cyclodestructive Procedures - (Items 42770)

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

TN.8.83 Insertion of drainage device for glaucoma (Item 42752)

Item 42752 provides for the insertion of a drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

TN.8.84 Laser Trabeculoplasty - (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 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

TN.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 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.

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SYDNEY NSW 2001

TN.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 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.

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PO Box 9822

SYDNEY NSW 2001

TN.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 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.

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SYDNEY NSW 2001

TN.8.88 Division of Suture by Laser - (Item 42794)

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

TN.8.89 Ophthalmic Sutures - (Item 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

TN.8.90 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 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.

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TN.8.91 Abrasive Therapy/Resurfacing - (Items 45021 to 45026)

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel[®]) laser therapy.

TN.8.92 Escharotomy - (Item 45054)

Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

TN.8.93 Local Skin Flap - Definition

Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

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

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 45201, claimable once per defect. Additional flaps are to be claimed under Item 45202, if clinically indicated.

Note: refer to T8.128 for MBS item 45202 for circumstances where other services might involve flap repair.

TN.8.94 Free Grafting to Burns - (Items 45406 to 45418)

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

TN.8.95 Revision of Scar - (Items 45506 to 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31206 to 31225 should be claimed.

TN.8.96 Augmentation Mammaplasty - (Items 45524, 45527 and 45528)

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 the Department of Human Services, 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 the Department of Human Services for prospective approval for proposed surgery.

TN.8.97 Breast Reconstruction, Myocutaneous Flap - (Item 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165-30179 (lipectomy items) should not be claimed in association with item 45530 as stated in the Health Insurance (General Medical Services Table) Regulations.

TN.8.98 Breast Prosthesis, Removal and Replacement of - (Items 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.

TN.8.99 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 inframammary 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 the Department of Human Services for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in Confidence'. These items are payable only once per patient.

Applications for approval should be addressed to:

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PO Box 9822

SYDNEY NSW 2001

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

TN.8.100 Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

TN.8.101 Liposuction - (Items 45584, 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 preoperative 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 the Department of Human Services for Prospective approval for proposed surgery.

TN.8.102 Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)

Benefits are payable under items 45587 and 45588 for face-lift operations performed 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 the Department of Human Services for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in Confidence'.

Applications for approval should be addressed to:

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SYDNEY NSW 2001

Practitioners may also apply to the Department of Human Services 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.

TN.8.103 Reduction of Eyelids - (Items 45617 and 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits.

TN.8.104 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 the Department of Human Services for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in Confidence'.

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

TN.8.105 Contour Restoration - (Item 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

TN.8.106 Vermilionectomy - (Item 45669)

Item 45669 covers treatment of the entire lip.

TN.8.107 Osteotomy of Jaw - (Items 45720 to 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

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

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

TN.8.108 Genioplasty - (Item 45761)

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

TN.8.109 Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)

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

TN.8.110 Fracture of Mandible or Maxilla - (Items 45975 to 45996)

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

TN.8.111 Reduction of Dislocation or Fracture

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

TN.8.112 Removal of Multiple Exostoses (Items 47933 and 47936)

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

TN.8.113 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.

TN.8.114 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.

TN.8.115 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.

TN.8.116 Wrist Surgery - (Items 49200 to 49227)

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

TN.8.117 Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

TN.8.118 Paediatric Patients - (Items 50450 to 50658)

For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

TN.8.119 Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

TN.8.120 Unresectable primary malignant tumour of the liver destruction of by open or laparoscopic radiofrequency ablation or microwave tissue ablation- (Item 50952)

A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

TN.8.121 Paracentesis of anterior chamber or vitreous cavity and/or intravitreal injection - (Items 42738 to 42740)

Items 42738 and 42739 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery.

Item 42739 should be claimed for patients requiring anaesthetic services for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

- nystagmus or eye movement disorder;

- cognitive impairment precluding safe intravitreal injection without sedation;
- a patient under the age of 18 years;
- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or

- endophthalmitis or other inflammation requiring more extensive anaesthesia (eg peribulbar).

Practitioners billing item 42739 must keep clinical notes outlining the basis for the use of anaesthetic.

Item 42740 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery including with a service to which Item 42809 (retinal photocoagulation) applies.

TN.8.122 Bone Graft (Items 48200-48242 and 48642-48651)

Bone graft substitute materials can be used for the purpose of bone graft for items 48200-48242 and 48642-48651.

TN.8.123 Vulvoplasty and Labioplasty - (Items 35533 and 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation and major congenital anomalies of the uro-gynaecological tract which are not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for localised gigantism which is causing significant functional impairment.

Medicare benefits are not payable for non-therapeutic cosmetic services.

Claims for benefits for item 35534 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 evidence to enable the Department of Human Services to determine the eligibility of the service for the payment of benefits.

Evidence should include a detailed clinical history outlining the functional impairment and the medical need for reconstructive surgery of the vulva and/or labia. Photographic evidence may not be required for this item.

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

Applications for Approval should be addressed to:

The MCRP Officer

PO Box 9822

SYDNEY NSW 2001

TN.8.124 Treatment of Wrist and Finger Fractures - (Items 47301 to 47319, and 47361 to 47373)

- For the purposes of these items, fixation includes internal and external.
- Regarding item 47362, major regional anaesthesia includes bier block.

TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31376)

The necessary excision diameter (or defect size) refers to the lesion size plus a clinically appropriate margin of healthy tissue required with the intent of complete surgical excision. Measurements should be taken prior to excision. Margin size should be determined in line with NHMRC guidelines:

Clinical practice guide - Basal cell carcinoma, squamous cell carcinoma(and related lesions)-a guide to clinical management in Australia. November 2008. Cancer Council Australia and; Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand (2008).

For the purpose of Items 31356 to 31376 the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: <u>Determining lesion size for MBS item selection</u>.

Practitioners must retain copies of histological reports and any other supporting evidence (patient notes, photographs etc). Photographs should include scale.

An episode of care includes both the excision and closure for the same defect, even when excision and closure occur at separate attendances.

Definitive surgical excision for items 31371 to 31376 means surgical removal with adequate margins as part of the curative management of the malignancies specified in these items.

An incomplete surgical excision of a malignant skin lesion with curative intent should be billed as a malignant skin lesion excision item even when further surgery is needed. Wide excision of the primary tumour bed following local excision of a primary melanoma, appendageal carcinoma, malignant connective tissue or merkel cell carcinoma of the skin may be claimed using item 31371, 31372, 31373, 31374, 31375 or 31376, depending on the location of the malignancy and the size of the excision diameter.

For Items 31356 to 31370, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous witha free margin).

Clinical evidence may be supported by patient notes, photographs of the affected area and pathology reports.

TN.8.127 Interpretation of femoroacetabular impingement (FAI) restriction (items 48424, 49303,49366)

Patients presenting with hip dysplasia, Perthes Disease and Slipped Upper Femoral Epiphysis (SUFE) are eligible for treatment under items 49366, 49303 and 48424.

TN.8.132 Transcatheter occlusion of left atrial appendage for stroke prevention (item 38276)

Explanatory Note

A contraindication to lifelong anticoagulation is defined as:

i) a previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy,

ii) a blood dyscrasia, or

iii) a vascular abnormality predisposing to potentially life threatening haemorrhage

The procedure is performed as a hospital service.

TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

Endoscopic upper GI stricture services 41819 and 41820 have been consolidated under item 30475. This consolidated item will allow any endoscopic technique to be performed for oesophageal through to gastroduodenal procedures and will include imaging intensification if done. The fee is the same as item 41819 which higher than item 30475 but lower than 41820.

TN.8.134 Application of items 32084, 32087, 32090 and 32093

If a service to which item 32084, 32087, 32090 or 32093 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Item 38495 applies only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a patient who has been assessed as suitable to receive the procedure.

TAVI Practitioner

For item 38495 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules* for the Accreditation of TAVI Practitioners, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, www.tavi.org.au.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

TAVI Hospital

For item 38495 a TAVI Hospital means a hospital, as defined by subsection 121-5(5) of the *Private Health Insurance Act 2007*, that is clinically accepted as being a facility that is suitable for TAVI procedures to be performed at.

The *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners* developed by Cardiac Accreditation Services Limited provides guidance on what are considered by the sector as minimum requirements that must be met in order to be a clinically acceptable facility that is suitable for TAVI procedures to be performed at.

Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners can be accessed via www.tavi.org.au.

TAVI Patient

For item 38495 a TAVI Patient is a patient who, as a result of a TAVI Case Conference, has been recommended as being suitable to receive the service described in item 38495.

A TAVI Case Conference is a process by which:

- (a) there is a team of 3 or more participants, where:
 - (i) the first participant is a cardiothoracic surgeon; and
 - (ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:

- (i) the patient's risk and technical suitability for a surgical aortic valve replacement; and
- (ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and

(d) the particulars of the assessment and recommendation are recorded in writing.

While benefits are payable for an eligible TAVI Case Conference under Items 6080 and 6081, a claim for these services does not have to be made in order for a benefit to be paid under Item 38495. Item 38495 is only payable once per patient in a five year period.

TN.8.136 Corneal Collagen Cross Linking (Item 42652)

Evidence of progression in patients over the age of twenty five is determined by the patient history including an objective change in tomography or refraction over time. Evidence of progression in patients aged twenty five years or younger is determined by patient history including an objective change in tomography or refraction over time and/or posterior elevation data and objective documented progression at a subclinical level.

TN.9.1 Assistance at Operations - (Items 51300 to 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

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

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

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	Multiple Operation Rule - Assistant
Item A - \$300@100%	Item A (Assist.) - \$300@100%
Item B - \$250@50%	Item B (No Assist.)
Item C - \$200@25%	Item C (Assist.) - \$200@50%
Item D - \$150@25%	Item D (Assist.) - \$150@25%

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

Surgeons Operating Independently

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

TN.9.2 Benefits Payable under Item 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

TN.9.3 Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

TN.9.4 Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

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

TN.9.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

TN.10.1 Relative Value Guide For Anaesthetics - (Group T10)

Overview of the RVG

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Department of Human Services website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the MBS fee for anaesthesia in connection with a procedure is comprised of up to three components:

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

2. The time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136); and

3. Where appropriate, modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020).

Assistance at anaesthesia

To establish the fee for the assistant service items 25200 and 25205, both services have been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers as appropriate to determine the MBS fee.

Whole body perfusion

Where whole body perfusion is performed, the MBS fee is determined by adding together the following:

1. The base units allocated to the service (item 22060);

2. The time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136); and

3. Where appropriate, modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 - 25020).

TN.10.2 Eligible Services

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

TN.10.3 RVG Unit Values Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- *for anaesthesia*, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- *for assistance at anaesthesia*, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- *for perfusion*, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

For statistical purposes, a separate MBS item applies to every 5 minute increment for anaesthetic services between 15 minutes and 2 hours duration. For or these services, the appropriate 5 minute item number should be included on accounts.

Modifying Units (25000 - 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000). This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
- a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
- a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
- a patient who has renal failure requiring regular dialysis.

ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005). This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or

- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:
- severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
- severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010). This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.
- **NOTE:** It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:
- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle.
- Where the patient is less than 12 months or age or 70 years or greater (item 25015).
- For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).
- For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).
- For a perfusion service in association with *after hours emergency surgery (item 25050).

* **NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After

Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

TN.10.4 Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION		SCHEDULE FEE
RVG	Anaesthesia Service	Units	SCHEDULE FEE (Units x \$ 19.45)
20840	Anaesthesia for resection of perforated bowel	6	\$116.70
23200	Time - 4 hours 40 minutes		\$466.80
25000	0 Modifier - Physical status		\$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 2		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 x 50% = \$330.65

Definition of Radical Surgery for the RVG

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems. See notes T10.18 and T10.22 which clarify the definitions of the words "extensive" and "radical" used in items 20192 and 20474.

Multiple Anaesthesia Services

Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for Cholecystectomy	8	\$155.60
20752	Incisional Hernia	6	(lower value - fee not payable) \$116.70
23111	Time - 2hrs 30mins	11	\$213.95
25015	Physical Status - Over 70	1	\$19.45

Prolonged Anaesthesia

Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

TN.10.5 Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation) Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists (ANZCA).

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;

- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;

- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and

- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;

- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;

- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;

- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

TN.10.6 Account Requirements

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

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

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

- **the perfusionist's account** must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

TN.10.7 General Information

The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.9).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

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

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

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

TN.10.8 Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services <u>other</u> than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

Items 22012 and 22014

Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

TN.10.9 Assistance in the Administration of Anaesthesia

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist

Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:-

(i) the need for invasive monitoring (intravascular or transoesophageal); or

- (ii) organ transplantation; or
- (iii) craniofacial surgery; or
- (iv) major tumour resection; or
- (v) separation of conjoint twins.

TN.10.10 Perfusion Services - (Items 22055 to 22075)

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

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate, i.e.

(a) the basic units allocated to whole body perfusion under item 22060:

22060 WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (See para T10.10 of explanatory notes to this Category)

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

plus, where appropriate

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

25015 ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient's age is up to one year or 70 years or greater (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Items 22065 and 22070 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists (ANZCA) *Guidelines for Major Extracorporeal Perfusion* (PS27 2015).

Benefits are not payable if another person primarily and/or continuously operates the HLM.

TN.10.11 Anaesthesia as a Therapeutic Procedure - (Item 21965)

Claims for benefits for this service 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 to:

The MCRP Officer

PO Box 9822

SYDNEY NSW 2001

TN.10.12 Discontinued Procedure - (Item 21990)

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

TN.10.13 Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

Claims for benefits for this service 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 to:

The MCRP Officer

PO Box 9822

SYDNEY NSW 2001

TN.10.14 Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

TN.10.15 Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

TN.10.16 Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

TN.10.17 Intra-operative Blocks for Post Operative Pain - (Items 22031 to 22050)

Benefits are only payable for intra-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22050.

TN.10.18 Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

TN.10.19 Intrathecal or Epidural Injection for Control of Post-operative Pain - Initial - (Item 22031)

Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

TN.10.20 Intrathecal or Epidural Injection for Control of Post-operative Pain - Subsequent - (Item 22036)

Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

TN.10.21 Regional or Field Nerve Blocks for Post-operative Pain - (Items 22040 - 22050)

Benefits are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

TN.10.22 Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

TN.10.23 Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

TN.10.24 Anaesthesia for Femoral Artery Embolectomy - (Item 21274)

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

TN.10.25 Anaesthesia for Cardiac Catheterisation - (Item 21941)

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

TN.10.26 Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)

Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

TN.10.27 Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

TN.10.28 Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

TN.10.29 Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

TN.11.1 Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently three botulinum toxin agents with TGA registration (Botox®, Dysport® and Xeomin®). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is recognised as an eligible medical practitioner for the relevant indication under the arrangements under Section 100 of the *National Health Act 1953* (the Act) relating to the use and supply of botulinum toxin. The specialist qualifications required to administer botulinum toxin vary across the indications for which the medicine is listed on the PBS, and are detailed within the relevant PBS restrictions available at: www.pbs.gov.au/browse/section100-mf

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the PBS listing for the supply of the medicine for this indication under Section 100 of the *Act*.

Item 18362 for the treatment of severe primary axillary hyperhidrosis allows for a maximum number of 3 treatments per patient in a 12 month period, with no less than 4 months to elapse between treatments.

Botulinum toxin which is not supplied and administered in accordance with the arrangements under Section 100 of the *Act* is not required to be provided free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare. Since 1 September 2015, PBS patient co-payments have applied to botulinum toxin supplied and administered in accordance with the arrangements under Section 100 of the Act.

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

TR.8.1 Mechanical thrombectomy - (Item 35414)

For the purposes of this item, *eligible stroke centre* means a facility that:

(a) has a designated stroke unit;

(b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:

(i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;

(ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and

(iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;

(c) has dedicated endovascular angiography facilities; and

(d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

Conjoint Committee for Recognition of Training in Interventional Neuroradiology (CCINR)

CCINR comprises representatives from the Australian and New Zealand Society of Neuroradiology (ANZSNR), the Neurosurgical Society of Australasia (NSA) and the Australian and New Zealand Association of Neurologists (ANZAN). For the purposes of this item, specialists or consultant physicians performing this procedure must have training recognised by CCINR, and the Department of Human Services notified of that recognition.

THERAPEUTIC PROCEDURES ITEMS

T1. MIS PROCE	CELLANEOUS THERAPEUTIC 1. HYPERBARIC OXYGEN THERAPY DURES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. Hyperbaric Oxygen Therapy
	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance.
13015	(See para TN.1.1 of explanatory notes to this Category) Fee: \$254.75 Benefit: 75% = \$191.10 85% = \$216.55
	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance
13020	(See para TN.1.1 of explanatory notes to this Category) Fee: \$258.85 Benefit: 75% = \$194.15 85% = \$220.05
	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour)
13025	(See para TN.1.1 of explanatory notes to this Category) Fee: \$115.70 Benefit: 75% = \$86.80 85% = \$98.35
	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of ar hour)
13030	(See para TN.1.1 of explanatory notes to this Category) Fee: \$163.45 Benefit: 75% = \$122.60 85% = \$138.95
T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 2. DIALYSIS
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. Dialysis
	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day
13100	(See para TN.1.2 of explanatory notes to this Category) Fee: \$136.65 Benefit: 75% = \$102.50 85% = \$116.20
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance

	CELLANEOUS THERAPEUTIC DURES 2. DIALYSIS
TROOL	time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day
	(See para TN.1.2 of explanatory notes to this Category) Fee: $$71.20$ Benefit: $75\% = 53.40 $85\% = 60.55
	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year
13104	(See para TN.1.3 of explanatory notes to this Category) Fee: \$147.95 Benefit: 85% = \$125.80
	DECLOTTING OF AN ARTERIOVENOUS SHUNT
13106	Fee: \$121.35 Benefit: 75% = \$91.05 85% = \$103.15
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)
13109	Fee: \$227.75 Benefit: 75% = \$170.85 85% = \$193.60
	TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.)
13110	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.) Fee: \$136.65 Benefit: 75% = \$102.50 85% = \$116.20
	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	Group T1. Miscellaneous Therapeutic Procedures
	Group T1. Miscellaneous Therapeutic Procedures Subgroup 3. Assisted Reproductive Services
13200	Subgroup 3. Assisted Reproductive Services 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
13200	Subgroup 3. Assisted Reproductive Services 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 (See para TN.1.4 of explanatory notes to this Category) Fee: \$3,110.75 Benefit: 75% = \$2333.10

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	Fee: \$2,909.75 Benefit: 75% = \$2182.35 85% = \$2828.05 Extended Medicare Safety Net Cap: \$2,432.15
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle
12202	(See para TN.1.4 of explanatory notes to this Category) Fee: \$465.55 Benefit: 75% = \$349.20 85% = \$395.75 Extended Medicore Sofety Nat Comp. \$64.05
13202	Extended Medicare Safety Net Cap: \$64.95OVULATION MONITORING SERVICES, for artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies
13203	(See para TN.1.4 of explanatory notes to this Category) Fee: \$486.75 Benefit: 75% = \$365.10 85% = \$413.75 Extended Medicare Safety Net Cap: \$108.15
	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies
13206	(See para TN.1.4 of explanatory notes to this Category) Fee: \$465.55 Benefit: 75% = \$349.20 85% = \$395.75 Extended Medicare Safety Net Cap: \$64.95
	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle
13209	(See para TN.1.4 of explanatory notes to this Category) Fee: \$84.70 Benefit: 75% = \$63.55 85% = \$72.00 Extended Medicare Safety Net Cap: \$10.90
	Professional attendance on a patient by a specialist practising in his or her specialty if:
	(a) the attendance is by video conference; and
	(b) item 13209 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
10010	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
13210	

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
	(See para TN.1.21 of explanatory notes to this Category) Derived Fee: 50% of the fee for item 13209. Benefit: 85% of the derived fee Extended Medicare Safety Net Cap: \$5.30
	Occyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.)
13212	(See para TN.1.4 of explanatory notes to this Category) Fee: \$354.45 Benefit: 75% = \$265.85 85% = \$301.30 Extended Medicare Safety Net Cap: \$70.35
	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination-only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.)
13215	(See para TN.1.4 of explanatory notes to this Category) Fee: \$111.10 Benefit: 75% = \$83.35 85% = \$94.45 Extended Medicare Safety Net Cap: \$48.70
	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.)
13218	(See para TN.1.4, TN.1.5 of explanatory notes to this Category) Fee: \$793.55 Benefit: 75% = \$595.20 85% = \$711.85 Extended Medicare Safety Net Cap: \$702.65
	Preparation of semen for the purpose of artificial insemination-only if rendered in connection with a service to which item 13203 applies
13221	(See para TN.1.4 of explanatory notes to this Category)Fee: $$50.80$ Benefit: $75\% = 38.10 $85\% = 43.20 Extended Medicare Safety Net Cap: $$21.70$
	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies
13251	(See para TN.1.5 of explanatory notes to this Category) Fee: \$417.95 Benefit: 75% = \$313.50 85% = \$355.30 Extended Medicare Safety Net Cap: \$108.15
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required
13290	Fee: \$204.25 Benefit: 75% = \$153.20 85% = \$173.65
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

		3. ASSISTED REPRODUCTIVE SERVICES
		on device including catheterisation and drainage of bladder where required, under tic, in a hospital (Anaes.)
	Fee: \$408.70	Benefit: 75% = \$306.55 85% = \$347.40
	CELLANEOUS T DURES	HERAPEUTIC 4. PAEDIATRIC & NEONATA
	Group T1. Misc	ellaneous Therapeutic Procedures
		Subgroup 4. Paediatric & Neonatal
		R SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or vein in a neonate
13300	Fee: \$56.95	Benefit: 75% = \$42.75 85% = \$48.45
	UMBILICAL A	RTERY CATHETERISATION with or without infusion
13303	Fee: \$84.40	Benefit: 75% = \$63.30 85% = \$71.75
	BLOOD TRANS from donor	FUSION with venesection and complete replacement of blood, including collection
13306	Fee: \$334.10	Benefit: 75% = \$250.60 85% = \$284.00
	BLOOD TRANS	SFUSION with venesection and complete replacement of blood, using blood already
13309	Fee: \$284.85	Benefit: 75% = \$213.65 85% = \$242.15
	BLOOD for path PUNCTURE IN	ology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN INFANTS
13312	Fee: \$28.45	Benefit: 75% = \$21.35 85% = \$24.20
	CENTRAL VEI	N CATHETERISATION - by open exposure in a person under 12 years of age (Anaes.
13318	Fee: \$227.45	of explanatory notes to this Category) Benefit: 75% = \$170.60 85% = \$193.35
	CENTRAL VEI	N CATHETERISATION in a neonate via peripheral vein (Anaes.)
13319	Fee: \$227.45	Benefit: 75% = \$170.60 85% = \$193.35
	CELLANEOUS T DURES	HERAPEUTIC 5. CARDIOVASCULA
	Group T1. Misc	ellaneous Therapeutic Procedures
		Subgroup 5. Cardiovascular
		NOF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the surgery (Anaes.)
13400	Fee: \$96.80	Benefit: 75% = \$72.60 85% = \$82.30

PROCE	CELLANEOUS THERAPEUTIC DURES 6. GASTROENTEROLOGY	
	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 6. Gastroenterology	
	GASTRO-OESOPHAGEAL balloon intubation, for control of bleeding from gastric oesophageal varices	
13506	(See para TN.8.2 of explanatory notes to this Category) Fee: \$184.50 Benefit: 75% = \$138.40 85% = \$156.85	
T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 8. HAEMATOLOGY	
	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 8. Haematology	
	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.)	
13700	Fee: \$333.25 Benefit: 75% = \$249.95 85% = \$283.30	
	TRANSFUSION OF BLOOD, including collection from donor	
13703	Fee: \$119.50 Benefit: 75% = \$89.65 85% = \$101.60	
	TRANSFUSION OF BLOOD or bone marrow already collected	
13706	(See para TN.1.7 of explanatory notes to this Category) Fee: \$83.35 Benefit: 75% = \$62.55 85% = \$70.85	
	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation	
13709	(See para TN.1.8 of explanatory notes to this Category) Fee: \$48.45 Benefit: 75% = \$36.35 85% = \$41.20	
	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	
13750	Fee: \$136.65 Benefit: 75% = \$102.50 85% = \$116.20	
	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuo 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	
13755	Fee: \$136.65 Benefit: 75% = \$102.50 85% = \$116.20	
	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda	
13757	Fee: \$72.95 Benefit: 75% = \$54.75 85% = \$62.05	
13760	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous	

T1. MISCELLA PROCEDURES	NEOUS THERAPEUTIC	8. HAEMATOLOGY
stem	cell transplantation as an adjunct to high dose chemotherapy for:	
	mosensitive intermediate or high grade non-Hodgkin's lymphoma at hig line chemotherapy; or	h risk of relapse following
. Hod	lgkin's disease which has relapsed following, or is refractory to, chemot	herapy; or
	te myelogenous leukaemia in first remission, where suitable genotypical vailable for allogeneic bone marrow transplant; or	ly matched sibling donor is
. mul	tiple myeloma in remission (complete or partial) following standard dos	se chemotherapy; or
. sma	Il round cell sarcomas; or	
. prin	nitive neuroectodermal tumour; or	
. gerr	. germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy.	
. gerr		
- perf	formed under the supervision of a consultant physician - each day.	
Fee:	\$762.60 Benefit: 75% = \$571.95 85% = \$680.90	
T1. MISCELLA	NEOUS THERAPEUTIC 9. PROCEDURES ASSOC	IATED WITH INTENSIVE

T1. MISCELLANEOUS THERAPEUTIC9. PROCEDURES ASSOCIATED WITH INTENSIVEPROCEDURESCARE AND CARDIOPULMONARY SUPPORT

	Group T1. Miscellaneous Therapeutic Procedures		
	Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support		
	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.)		
(See para TN.1.6 of explanatory notes to this Category) 13815 Fee: \$85.25 Benefit: 75% = \$63.95 85% = \$72.50			
	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.)		
13818	(See para TN.1.10 of explanatory notes to this Category) Fee: \$113.70 Benefit: 75% = \$85.30 85% = \$96.65		
	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day		
13830	Fee: \$75.35 Benefit: 75% = \$56.55 85% = \$64.05		
	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes		
13839	Fee: \$23.05 Benefit: 75% = \$17.30 85% = \$19.60		
	INTRAARTERIAL CANNULATION for the purpose of taking multiple arterial blood samples for blood gas analysis		
13842	(See para TN.1.10 of explanatory notes to this Category) Fee: \$69.30 Benefit: 75% = \$52.00 85% = \$58.95		
13847	COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day including		

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES

9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT

	initial and subsequent consultations and monitoring of parameters (Anaes.)	
	(See para TN.1.10 of explanatory notes to this Category)	
	Fee: \$156.10 Benefit: 75% = \$117.10 85% = \$132.70	
	COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the	
	first, including associated consultations and monitoring of parameters	
	(See para TN.1.10 of explanatory notes to this Category)	
13848	Fee: \$131.05 Benefit: 75% = \$98.30 85% = \$111.40	
	CIRCULATORY SUPPORT DEVICE, management of, on first day	
13851	Fee: \$493.65 Benefit: 75% = \$370.25 85% = \$419.65	
	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first	
13854	Fee: \$114.85 Benefit: 75% = \$86.15 85% = \$97.65	
	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL 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	
	(See para TN.1.10 of explanatory notes to this Category)	
13857	Fee: \$146.40 Benefit: 75% = \$109.80 85% = \$124.45	

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES

10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT

	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 10. Management And Procedures Undertaken In An Intensive Care Unit	
	(Note: See para T1.8 of Explanatory Notes to this	
	Category for definition of an Intensive Care Unit)	
	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 (H)	
13870	(See para TN.1.9, TN.1.11, TN.1.10 of explanatory notes to this Category) Fee: \$362.10 Benefit: 75% = \$271.60	
	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 (H)	
13873	(See para TN.1.9, TN.1.11 of explanatory notes to this Category) Fee: \$268.60 Benefit: 75% = \$201.45	
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	

	CELLANEOUS THERAPEUTIC	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
		nmediately available and exclusively rostered for sure on any calendar day (up to a maximum of 4
	(See para TN.1.9, TN.1.11, TN.1.10 of explanatory m Fee: \$76.90 Benefit: 75% = \$57.70	notes to this Category)
	AIRWAY ACCESS, ESTABLISHMENT OF A VENTILATION, in an Intensive Care Unit, not specialist or consultant physician for the purpos	in association with any anaesthetic service, by a
13881	(See para TN.1.9, TN.1.11 of explanatory notes to th Fee: \$146.40 Benefit: 75% = \$109.80	is Category)
	invasive means where the only alternative to no	are Unit, management of, by invasive means, or by non- n-invasive ventilatory support would be invasive t physician who is immediately available and exclusively
13882	(See para TN.1.9, TN.1.11 of explanatory notes to th Fee: \$115.25 Benefit: 75% = \$86.45	is Category)
		NO VENOUS HAEMOFILTRATION, in an intensive tant physician who is immediately available and first day (H)
13885	(See para TN.1.9, TN.1.11 of explanatory notes to th Fee: \$153.65 Benefit: 75% = \$115.25	is Category)
		NO VENOUS HAEMOFILTRATION, in an intensive tant physician who is immediately available and a day subsequent to the first day (H)
13888	(See para TN.1.9, TN.1.11 of explanatory notes to th Fee: \$76.90 Benefit: 75% = \$57.70	is Category)
	CELLANEOUS THERAPEUTIC	11. CHEMOTHERAPEUTIC PROCEDURES
	Group T1. Miscellaneous Therapeutic Procee	dures
	Subgroup 11. Cl	hemotherapeutic Procedures
	into a vein, or a butterfly needle, or the side-arm than 1 hours duration - payable once only on the	ne administration of drugs used immediately prior to, or
13915	(See para TN.1.12 of explanatory notes to this Categring Fee: \$65.05 Benefit: 75% = \$48.80 85	
	CYTOTOXIC CHEMOTHERAPY, administra duration but not more than 6 hours duration - pa	tion of, by intravenous infusion of more than 1 hours ayable once only on the same day
13918	Fee: \$97.95 Benefit: 75% = \$73.50 85	% = \$83.30
13921	CYTOTOXIC CHEMOTHERAPY, administra	tion of, by intravenous infusion of more than 6 hours

	HERAPEUTIC	11. CHEMOTHERAPEUTIC PROCEDURES
duration - for the	e first day of treatment	
Fee: \$110.80	Benefit: 75% = \$83.1	0 85% = \$94.20
		inistration of, by intravenous infusion of more than 6 hours first in the same continuous treatment episode
Fee: \$65.25	Benefit: 75% = \$48.9	05 85% = \$55.50
into an artery, a	butterfly needle or the sid	inistration of, either by intra-arterial push technique (directly le-arm of an infusion) or by intra-arterial infusion of not more on the same day
Fee: \$84.40	Benefit: 75% = \$63.3	30 85% = \$71.75
		inistration of, by intra-arterial infusion of more than 1 hours on - payable once only on the same day
Fee: \$117.80	Benefit: 75% = \$88.3	35 85% = \$100.15
		inistration of, by intra-arterial infusion of more than 6 hours
Fee: \$130.70	Benefit: 75% = \$98.0	85% = \$111.10
		inistration of, by intra-arterial infusion of more than 6 hours first in the same continuous treatment episode
Fee: \$85.15	Benefit: 75% = \$63.9	85% = \$72.40
		loading of, with a cytotoxic agent or agents, not being a service 3915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or
(See para TN.1.13 Fee: \$97.95		
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		
(See para TN.1.13 of explanatory notes to this Category) Fee: \$65.25 Benefit: 75% = \$48.95 85% = \$55.50		
LONG-TERM I accessing of	MPLANTED DRUG DE	LIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY,
Fee: \$52.50	Benefit: 75% = \$39.4	40 85% = \$44.65
CYTOTOXIC A	GENT, instillation of, in	to a body cavity
Fee: \$65.25	Benefit: 75% = \$48.9	95 85% = \$55.50
	HERAPEUTIC	12. DERMATOLOGY
Group T1. Misc	ellaneous Therapeutic F	Procedures
	S	Subgroup 12. Dermatology
	DURESduration - for theFee: \$110.80CYTOTOXIC Cduration - on eaceFee: \$65.25CYTOTOXIC Cinto an artery, athan 1 hours durFee: \$84.40CYTOTOXIC Cduration but notFee: \$117.80CYTOTOXIC Cduration but notFee: \$130.70CYTOTOXIC Cduration - for theFee: \$130.70CYTOTOXIC Cduration - on eaceFee: \$85.15IMPLANTED Passociated with a13945 applies(See para TN.1.13Fee: \$97.95AMBULATORinfusion of the aassociated with a13945 applies(See para TN.1.13Fee: \$65.25LONG-TERM Iaccessing ofFee: \$65.25LONG-TERM Iaccessing ofFee: \$65.25LONG-TERM Iaccessing ofFee: \$65.25LONG-TERM Iaccessing ofFee: \$65.25CYTOTOXIC AFee: \$65.25	duration - for the first day of treatment Fee: \$110.80 Benefit: 75% = \$83.1 CYTOTOXIC CHEMOTHERAPY, admiduration - on each day subsequent to the f Fee: \$65.25 Benefit: 75% = \$48.5 CYTOTOXIC CHEMOTHERAPY, adminito an artery, a butterfly needle or the sid than 1 hours duration - payable once only Fee: \$84.40 Benefit: 75% = \$63.3 CYTOTOXIC CHEMOTHERAPY, adminito an artery, a butterfly needle or the sid than 1 hours duration - payable once only Fee: \$84.40 Benefit: 75% = \$63.3 CYTOTOXIC CHEMOTHERAPY, adminito but not more than 6 hours duration duration but not more than 6 hours duration Fee: \$117.80 Benefit: 75% = \$88.3 CYTOTOXIC CHEMOTHERAPY, adminitour for the first day of treatment Fee: \$130.70 Benefit: 75% = \$88.3 CYTOTOXIC CHEMOTHERAPY, adminitour on each day subsequent to the f Fee: \$130.70 Benefit: 75% = \$86.3 IMPLANTED PUMP OR RESERVOIR, associated with a service to which item 13 13945 applies (See para TN.1.13 of explanatory notes to this fee: \$97.95 Benefit: 75% = \$74.5 AMBULATORY DRUG DELIVERY DF infusion of the agent or agents via the intrassociated with a service to which item 13 13945 applies (See para TN.1.13 of explanatory notes to this fee: \$65.25 Be

	1. MISCELLANEOUS THERAPEUTIC ROCEDURES 12. DERMATOLO	
	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	
14050	(See para TN.1.14 of explanatory notes to this Category)Fee: $$52.75$ Benefit: $75\% = 39.60 $85\% = 44.85	
	PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation	
14053	(See para TN.1.14 of explanatory notes to this Category)Fee: $$52.75$ Benefit: $75\% = 39.60 $85\% = 44.85	
	LASER PHOTOCOAGULATION using laser 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.)	
14100	Fee: \$152.50 Benefit: 75% = \$114.40 85% = \$129.65 Extended Medicare Safety Net Cap: \$122.00	
	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.)	
14106	(See para TN.1.15 of explanatory notes to this Category) Fee: \$152.50 Benefit: 75% = \$114.40 85% = \$129.65	
	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.)	
14109	(See para TN.1.15 of explanatory notes to this Category) Fee: \$187.35 Benefit: 75% = \$140.55 85% = \$159.25	
	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.)	
14112	(See para TN.1.15 of explanatory notes to this Category) Fee: \$221.75 Benefit: 75% = \$166.35 85% = \$188.50	
	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.)	
14115	(See para TN.1.15 of explanatory notes to this Category) Fee: $$256.50$ Benefit: $75\% = 192.40 $85\% = 218.05	

	SCELLANEOUS THERAPEUTIC EDURES 12. DERMATOLOGY		
	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.)		
14118	(See para TN.1.15 of explanatory notes to this Category) Fee: 325.75 Benefit: $75\% = 244.35 $85\% = 276.90		
	LASER PHOTOCOAGULATION using laser 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.)		
14124	(See para TN.1.15 of explanatory notes to this Category) Fee: $$152.50$ Benefit: $75\% = 114.40 $85\% = 129.65		
	SCELLANEOUS THERAPEUTIC EDURES 13. OTHER THERAPEUTIC PROCEDURES		
	Group T1. Miscellaneous Therapeutic Procedures		
	Subgroup 13. Other Therapeutic Procedures		
	GASTRIC LAVAGE in the treatment of ingested poison		
14200	Fee: \$59.80 Benefit: 75% = \$44.85 85% = \$50.85		
	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient		
14201	(See para TN.1.16 of explanatory notes to this Category) Fee: \$236.85 Benefit: 75% = \$177.65 85% = \$201.35 Extended Medicare Safety Net Cap: \$35.55		
	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953		
14202	(See para TN.1.16 of explanatory notes to this Category) Fee: \$119.90 Benefit: 75% = \$89.95 85% = \$101.95 Extended Medicare Safety Net Cap: \$18.00		
	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)		
14203	(See para TN.1.4, TN.1.17 of explanatory notes to this Category)Fee: $$51.15$ Benefit: $75\% = 38.40 $85\% = 43.50		
	HORMONE OR LIVING TISSUE IMPLANTATION by cannula		
14206	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) Fee: \$35.60 Benefit: 75% = \$26.70 85% = \$30.30		
	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent		
14209	Fee: \$88.70 Benefit: 75% = \$66.55 85% = \$75.40		

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDU	JRES
	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)	
14212	Fee: \$185.30 Benefit: 75% = \$139.00 85% = \$157.55	
	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain	
14218	Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30	
	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessin not being a service associated with a service to which item 13945 applies	g of,
14221	Fee: \$52.50 Benefit: 75% = \$39.40 85% = \$44.65	
	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, incluany electroencephalographic monitoring and associated consultation (Anaes.)	uding
14224	Fee: \$70.35 Benefit: 75% = \$52.80 85% = \$59.80	
	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity	
14227	(See para TN.1.18 of explanatory notes to this Category) Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30	
	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclo (Anaes.) (Assist.)	fen
14230	(See para TN.1.18 of explanatory notes to this Category) Fee: \$298.05 Benefit: 75% = \$223.55	
	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.)	
14233	(See para TN.1.18 of explanatory notes to this Category) Fee: \$361.90 Benefit: 75% = \$271.45 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.)	
14236	(See para TN.1.18 of explanatory notes to this Category) Fee: \$659.95 Benefit: 75% = \$495.00	
	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.)	
14239	(See para TN.1.18 of explanatory notes to this Category) Fee: \$159.40 Benefit: 75% = \$119.55	
	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management o severe chronic spasticity (Anaes.)	f
14242	(See para TN.1.18 of explanatory notes to this Category) Fee: \$473.65 Benefit: 75% = \$355.25	
14245	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours	

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES
	duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme
	(See para TN.1.19 of explanatory notes to this Category) Fee: \$97.95 Benefit: 75% = \$73.50 85% = \$83.30
T2. RA[DIATION ONCOLOGY 1. SUPERFICIAL
	Group T2. Radiation Oncology
	Subgroup 1. Superficial
	(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)
	RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given
	- 1 field
15000	Fee: \$42.55 Benefit: 75% = \$31.95 85% = \$36.20
	- 2 or more fields up to a maximum of 5 additional fields
15003	Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$17.10
	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied
	- 1 field
15006	Fee: \$94.35 Benefit: 75% = \$70.80 85% = \$80.20
	- 2 or more fields up to a maximum of 5 additional fields
15009	Derived Fee: The fee for item 15006 plus for each field in excess of 1, an amount of \$18.55
	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye
15012	Fee: \$53.45 Benefit: 75% = \$40.10 85% = \$45.45
T2. RAI	DIATION ONCOLOGY 2. ORTHOVOLTAGE
	Group T2. Radiation Oncology
Subgroup 2. Orthovoltage	
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week
	- 1 field
15100	(See para TN.2.1 of explanatory notes to this Category) Fee: $$47.70$ Benefit: $75\% = 35.80 $85\% = 40.55
	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)
15103	(See para TN.2.1 of explanatory notes to this Category)

T2. RAI	DIATION ONCOLOGY	2. ORTHOVOLTAGE
	Derived Fee: The fee for item 15100 plus for each field in	n excess of 1, an amount of \$18.80
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatme given at 2 treatments per week or less frequently	
	- 1 field	
15106	Fee: \$56.30 Benefit: 75% = \$42.25 85% = \$4	17.90
	- 2 or more fields up to a maximum of 5 additional fie	elds (rotational therapy being 3 fields)
15109	Derived Fee: The fee for item 15106 plus for each field in	n excess of 1, an amount of \$22.70
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE a applied 1 field	attendance at which single dose technique is
15112	Fee: \$120.25 Benefit: 75% = \$90.20 85% = \$1	02.25
	- 2 or more fields up to a maximum of 5 additional fie	lds (rotational therapy being 3 fields)
15115	Derived Fee: The fee for item 15112 plus for each field in	n excess of 1, an amount of \$47.30
T2. RAI		3. MEGAVOLTAGE
	Crown T2 Rediction Oncelery	
	Group T2. Radiation Oncology	
	Subgroup 3.	Megavoltage
	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given	
	- 1 field	
15211	Fee: \$54.70 Benefit: 75% = \$41.05 85% = \$4	16.50
	- 2 or more fields up to a maximum of 5 additional fie	
15214	Derived Fee: The fee for item 15211 plus for each field in	excess of 1, an amount of \$31.90
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung)	
15215	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$5	50.75
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator w without electron facilities - each attendance at which treatment is given - 1 field - treatment del primary site (prostate)	
15218	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$5	50.75
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered primary site (breast)	
15221	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$5	j0.75
	RADIATION ONCOLOGY TREATMENT, using a s without electron facilities - each attendance at which t	
	primary site for diseases and conditions not covered b	

T2. RA[DIATION ONCOLOGY 3. MEGAVOLTAGE		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site		
15227	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung)		
15230	Derived Fee: The fee for item 15215 plus for each field in excess of 1, an amount of \$37.95		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate)		
15233	Derived Fee: The fee for item 15218 plus for each field in excess of 1, an amount of \$37.95		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast)		
15236	Derived Fee: The fee for item 15221 plus for each field in excess of 1, an amount of \$37.95		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236		
15239	Derived Fee: The fee for item 15224 plus for each field in excess of 1, an amount of \$37.95		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site		
15242	Derived Fee: The fee for item 15227 plus for each field in excess of 1, an amount of \$37.95		
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung)		
15245	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75		
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate)		
15248	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75		
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast)		
15251	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75		
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		

T2. RAD	NATION ONCOLOGY	3. MEGAVOLTAGE	
	treatment is given - 1 field - treatment delivered to primary sit by items 15245, 15248 or 15251	e for diseases and conditions not covered	
	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75		
	RADIATION ONCOLOGY TREATMENT, using a dual pho minimum higher energy of at least 10MV photons, with electr treatment is given - 1 field - treatment delivered to secondary s	on facilities - each attendance at which	
15257	Fee: \$59.65 Benefit: 75% = \$44.75 85% = \$50.75		
	RADIATION ONCOLOGY TREATMENT, using a dual pho minimum higher energy of at least 10MV photons, with electr treatment is given - 2 or more fields up to a maximum of 5 add fields) - treatment delivered to primary site (lung)	on facilities - each attendance at which	
15260	Derived Fee: The fee for item 15245 plus for each field in excess of	of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate)		
15263	Derived Fee: The fee for item 15248 plus for each field in excess of	of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a dual pho minimum higher energy of at least 10MV photons, with electr treatment is given - 2 or more fields up to a maximum of 5 add fields) - treatment delivered to primary site (breast)	on facilities - each attendance at which	
15266	Derived Fee: The fee for item 15251 plus for each field in excess of	of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266		
15269	Derived Fee: The fee for item 15254 plus for each field in excess of	of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT, using a dual pho minimum higher energy of at least 10MV photons, with electr treatment is given - 2 or more fields up to a maximum of 5 add fields) - treatment delivered to secondary site	ton energy linear accelerator with a on facilities - each attendance at which	
15272	Derived Fee: The fee for item 15257 plus for each field in excess of	of 1, an amount of \$37.95	
	RADIATION ONCOLOGY TREATMENT with IGRT imagi	ng facilities undertaken:	
	(a) to implement an IMRT dosimetry plan prepared in accorda	ance with item 15565; and	
	(b) utilising an intensity modulated treatment delivery mode (a linear accelerator or by a helical non C-arm based linear acceleration which treatment is given.		
15275	Fee: \$182.90 Benefit: 75% = \$137.20 85% = \$155.50		
T2. RAD	NATION ONCOLOGY	4. BRACHYTHERAPY	
	Group T2. Radiation Oncology		

T2. RAD	IATION ONCOLOGY 4. BRACHYTHERAPY			
	Subgroup 4. Brachytherapy			
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)			
15303	Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45			
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)			
15304	Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45			
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)			
15307	Fee: \$676.80 Benefit: 75% = \$507.60 85% = \$595.10			
	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.)			
15308	Fee: \$676.80 Benefit: 75% = \$507.60 85% = \$595.10			
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)			
15311	Fee: \$333.20 Benefit: 75% = \$249.90 85% = \$283.25			
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)			
15312	Fee: \$330.80 Benefit: 75% = \$248.10 85% = \$281.20			
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)			
15315	Fee: \$654.25 Benefit: 75% = \$490.70 85% = \$572.55			
	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.)			
15316	Fee: \$654.25 Benefit: 75% = \$490.70 85% = \$572.55			
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)			
15319	Fee: \$406.05 Benefit: 75% = \$304.55 85% = \$345.15			
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)			
15320	Fee: \$406.05 Benefit: 75% = \$304.55 85% = \$345.15			
	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.)			
15323	Fee: \$722.00 Benefit: 75% = \$541.50 85% = \$640.30			
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			

T2. RAD	IATION ONCOLOGY 4. BRACHYTHERAP		
	automatic afterloading techniques (Anaes.)		
	Fee: \$722.00 Benefit: 75% = \$541.50 85% = \$640.30		
	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		
15327	Fee: \$785.45 Benefit: 75% = \$589.10 85% = \$703.75		
	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.)		
15328	Fee: \$785.45 Benefit: 75% = \$589.10 85% = \$703.75		
	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.)		
15331	Fee: \$745.80 Benefit: 75% = \$559.35 85% = \$664.10		
	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.)		
15332	Fee: \$745.80 Benefit: 75% = \$559.35 85% = \$664.10		
	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.)		
15335	Fee: \$676.80 Benefit: 75% = \$507.60 85% = \$595.10		
	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.)		
15336	Fee: \$676.80 Benefit: 75% = \$507.60 85% = \$595.10		
	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.		
15338	(See para TN.2.2 of explanatory notes to this Category) Fee: \$935.60 Benefit: 75% = \$701.70 85% = \$853.90		
	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural of spinal nerve block (Anaes.)		
15339	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		

T2. RAD	DIATION ONCOL	OGY		4. BRACHYTHERAPY
	Fee: \$190.30	Benefit: 75% = \$142.75 85	% = \$161.80	
		ON AND APPLICATION OF A e of less than 115 days including nasal sites		
15345	Fee: \$507.80	Benefit: 75% = \$380.85 85	% = \$431.65	
	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance			
15348	Fee: \$58.40	Benefit: 75% = \$43.80 85%	6 = \$49.65	
		ON WITH OR WITHOUT INIT diameter to an external surface	IAL APPLICATION OF RAI	DIOACTIVE MOULD not
15351	Fee: \$116.60	Benefit: 75% = \$87.45 85%	6 = \$99.15	
	CONSTRUCTION diameter to an e	DN AND INITIAL APPLICATI	ON OF RADIOACTIVE MO	ULD 5 cm. or more in
15354	Fee: \$141.50	Benefit: 75% = \$106.15 85	% = \$120.30	
	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance			
15357	Fee: \$40.05	Benefit: 75% = \$30.05 85%	6 = \$34.05	
T2. RAD	DIATION ONCOL	OGY	5. COMF	PUTERISED PLANNING
	Group T2. Radiation Oncology			
	Subgroup 5. Computerised Planning			
	RADIOTHERAPY PLANNING			
	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT or single area for treatment by a single field or parallel opposed fields (not being a service associated with service to which item 15509 applies)			
15500	(See para TN.2.3 of explanatory notes to this Category) Fee: \$242.65 Benefit: 75% = \$182.00 85% = \$206.30			
	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 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)			
15503	(See para TN.2.3 Fee: \$311.55	of explanatory notes to this Category Benefit: 75% = \$233.70 85		
	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or 0 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not bein service associated with a service to which item 15515 applies)		inverted Y fields, or of	
15506	(See para TN.2.3 Fee: \$465.30	of explanatory notes to this Category Benefit: $75\% = 349.00 85		
15509		ELD SETTING using a diagnos opposed fields (not being a servi		

T2. RAI	DIATION ONCOLOGY 5. COMPUTERISED PLANNING		
	applies)		
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80		
	RADIATION FIELD SETTING using a diagnostic xray unit 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)		
15512	(See para TN.2.3 of explanatory notes to this Category) Fee: \$271.10 Benefit: 75% = \$203.35 85% = \$230.45		
	RADIATION SOURCE LOCALISATION using a simulator 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		
15513	(See para TN.2.3 of explanatory notes to this Category)Fee: $\$306.55$ Benefit: $75\% = \$229.95$ $85\% = \$260.60$		
	RADIATION FIELD SETTING using a diagnostic xray unit 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)		
15515	(See para TN.2.3 of explanatory notes to this Category) Fee: \$392.50 Benefit: 75% = \$294.40 85% = \$333.65		
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks		
15518	(See para TN.2.3 of explanatory notes to this Category)Fee: $\$77.00$ Benefit: $75\% = \$57.75$ $85\% = \$65.45$		
	RADIATION DOSIMETRY by a CT interfacing planning 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		
15521	(See para TN.2.3 of explanatory notes to this Category) Fee: \$339.90 Benefit: 75% = \$254.95 85% = \$288.95		
	RADIATION DOSIMETRY by a CT interfacing planning 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		
15524	(See para TN.2.3 of explanatory notes to this Category) Fee: \$637.35 Benefit: 75% = \$478.05 85% = \$555.65		
	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		
15527	(See para TN.2.3 of explanatory notes to this Category) Fee: \$78.95 Benefit: 75% = \$59.25 85% = \$67.15		
	RADIATION DOSIMETRY by a non CT interfacing planning 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		
15530	(See para TN.2.3 of explanatory notes to this Category) Fee: \$352.15 Benefit: 75% = \$264.15 85% = \$299.35		
15533	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy		

T2. RAI	DIATION ONCOLOGY 5. COMPUTERISED PLANNIN
	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
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$667.70 Benefit: 75% = \$500.80 85% = \$586.00
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry
15536	(See para TN.2.3 of explanatory notes to this Category) Fee: \$266.90 Benefit: 75% = \$200.20 85% = \$226.90
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338
15539	(See para TN.2.3 of explanatory notes to this Category) Fee: \$627.30 Benefit: 75% = \$470.50 85% = \$545.60
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without intravenou contrast medium, where:
	(a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and
	(b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and
	(c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and
	(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images
15550	(See para TN.2.3 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95 85% = \$576.90
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY pre and post intravenous contrast medium, where:
	(a) treatment set up and technique specifications are in preparations for three dimensional conformal radiotherapy dose planning; and
	(b) patient set up and immobilisation techniques are suitable for reliable CT image volume data acquisition and three dimensional conformal radiotherapy treatment; and
	(c) a high-quality CT-image volume dataset must be acquired for the relevant region of interest to be planned and treated; and
	(d) the image set must be suitable for the generation of quality digitally reconstructed radiographic images
15553	(See para TN.2.3 of explanatory notes to this Category)Fee: $\$710.55$ Benefit: $75\% = \$532.95$ $85\% = \$628.85$
	SIMULATION FOR INTENSITY-MODULATED RADIATION THERAPY (IMRT), with or without intravenous contrast medium, if:
	1. treatment set-up and technique specifications are in preparations for three-dimensional conformal radiotherapy dose planning; and
15555	

T2. RAI	IATION ONCOLOGY 5. COMPUTERISED PLANNING
	2. patient set-up and immobilisation techniques are suitable for reliable CT-image volume data acquisition and three-dimensional conformal radiotherapy; and
	3. a high-quality CT-image volume dataset is acquired for the relevant region of interest to be planned and treated; and
	4. the image set is suitable for the generation of quality digitally-reconstructed radiographic images.
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$710.55 Benefit: 75% = \$532.95 85% = \$628.85
	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 1 COMPLEXITY where:
	(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
	(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
	(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
	(d) dose volume histograms must be generated, approved and recorded with the plan; and
	(e) a CT image volume dataset must be used for the relevant region to be planned and treated; and
	(f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images
15556	(See para TN.2.3 of explanatory notes to this Category) Fee: \$664.40 Benefit: 75% = \$498.30 85% = \$582.70
	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 2 COMPLEXITY where:
	(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
	(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
	(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.
15559	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

T2. RADI	ATION ONCOLOGY	5. COMPUTERISED PLANNING
	(See para TN.2.3 of explanatory notes to this Category Fee: \$866.55 Benefit: 75% = \$649.95 85%	
	DOSIMETRY FOR THREE DIMENSIONAL C COMPLEXITY - where:	ONFORMAL RADIOTHERAPY OF LEVEL 3
		mensional conformal treatment plan using CT image volume, three planning target volumes and one organ at
	(b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and	
	(i) two planning target volumes; or	
	(ii) two organ at risk dose goals or constrain	ts defined in the prescription.
	or	
		l conformal treatment plan using CT image volume ne planning target volume and three organ at risk dose
	or	
		MRI or PET) volume dataset used to define target and specified in dosimetry for three dimensional conformal
	or constraints and the prescription must specify the volume histograms must be generated, approved	gan at risk must be nominated as planning dose goals ne organs at risk as dose goals or constraints. Dose and recorded with the plan. A CT image volume dataset d and treated. The CT images must be suitable for the
15562	(See para TN.2.3 of explanatory notes to this Category Fee: \$1,120.75 Benefit: 75% = \$840.60 856	
	Preparation of an IMRT DOSIMETRY PLAN, w	hich uses one or more CT image volume datasets, if:
	(a) in preparing the IMRT dosimetry plan:	
	(i) the differential between target dose and no assessment by a radiation oncologist; and	ormal tissue dose is maximised, based on a review and
	(ii) all gross tumour targets, clinical targets, p volumes as defined in the prescription; and	planning targets and organs at risk are rendered as
	(iii) organs at risk are nominated as planning the organs at risk as dose goals or constraints;	dose goals or constraints and the prescription specifies and
Amend 15565		grams are generated in an inverse planned process, n prescription and plan details approved and recorded in

T2. RAD	DIATION ONCOLOGY	5. COMPUTERISED PLANNING	
	the plan; and		
	(v) a CT image volume dataset is used for the relevant	nt region to be planned and treated; and	
	(vi) the CT images are suitable for the generation of quality digitally reconstructed rad images; and		
	(b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical phys robust quality assurance processes that include:		
	(i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimato gantryposition (static or dynamic); and		
	(ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are completed on a linear accelerator; and		
	(iii) validating the accuracy of the derived IMRT dosimetry plan; and		
	(c) the final IMRT dosimetry plan is approved by the ra	adiation oncologist prior to delivery.	
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$3,313.85 Benefit: 75% = \$2485.40 85% = \$32	232.15	
T2. RAD	2. RADIATION ONCOLOGY 6. STEREOTACTIC RADIOSURGERY		
	Group T2. Radiation Oncology		
	Subgroup 6. Stereotactic Radiosurgery		
	STEREOTACTIC RADIOSURGERY, including all radi simulation, dosimetry and treatment	ation oncology consultations, planning,	
15600	Fee: \$1,702.30 Benefit: 75% = \$1276.75 85% = \$16	520.60	
T2. RAD	DIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMENT VERIFICATION	
	Group T2. Radiation Oncology		
	Subgroup 7. Radiation Oncolog	gy Treatment Verification	
	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or doub exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 157 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance).		
15700	(See para TN.2.4 of explanatory notes to this Category) 0 Fee: $$45.95$ Benefit: $75\% = 34.50 $85\% = 39.10		
	RADIATION ONCOLOGY TREATMENT VERIFICAT prescribed and reviewed by a radiation oncologist and no attendance at which treatment involving three or more fite attendance).	ot associated with item 15700 or 15710 - each	
15705	(See para TN.2.4 of explanatory notes to this Category) Fee: \$76.60 Benefit: 75% = \$57.45 85% = \$65.1	5	
	RADIATION ONCOLOGY TREATMENT VERIFICAT and reviewed by a radiation oncologist and not associate	TION - volumetric acquisition, when prescribed	

T2. RAD	7. RADIATION ONCOLOGY TREATMEN IATION ONCOLOGY VERIFICATION
	at which treatment involving three fields or more is verified (ie maximum one per attendance).
	(see para T2.5 of explanatory notes to this Category)
	(See para TN.2.4 of explanatory notes to this Category) Fee: \$76.60 Benefit: 75% = \$57.45 85% = \$65.15
	RADIATION ONCOLOGY TREATMENT VERIFICATION of planar or volumetric IGRT for IMRT, involving the use of at least 2 planar image views or projections or 1 volumetric image set to facilitate a 3-dimensional adjustment to radiation treatment field positioning, if:
	(a) the treatment technique is classified as IMRT; and
	(b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or reduced to minimise treatment related exposure of healthy or normal tissues; and
	(c) the decisions made using acquired images are based on action algorithms and are given effect immediately prior to or during treatment delivery by qualified and trained staff considering complex competing factors and using software driven modelling programs; and
	(d) the radiation treatment field positioning requires accuracy levels of less than 5mm (curative cases) of up to 10mm (palliative cases) to ensure accurate dose delivery to the target; and
	(e) the image decisions and actions are documented in the patient's record; and
	(f) the radiation oncologist is responsible for supervising the process, including specifying the type and frequency of imaging, tolerance and action levels to be incorporated in the process, reviewing the trend analysis and any reports and relevant images during the treatment course and specifying action protocol as required; and
	(g) when treatment adjustments are inadequate to satisfy treatment protocol requirements, replanning is required; and
	(h) the imaging infrastructure (hardware and software) is linked to the treatment unit and networked to an image database, enabling both on line and off line reviews.
15715	(See para TN.2.4 of explanatory notes to this Category) Fee: $$76.60$ Benefit: $75\% = 57.45 $85\% = 65.15
	8. BRACHYTHERAPY PLANNING AN IATION ONCOLOGY VERIFICATIO

	Group T2. Radiation Oncology	
	Subgroup 8. Brachytherapy Planning And Verification	
15800	BRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each atte(See para TN.2.4 of explanatory notes to this Category)Fee: \$96.30Benefit: 75% = \$72.2585% = \$81.90	endance.
	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 being a service to which Item 15513 applies.	
15850	Fee: \$199.50 Benefit: 75% = \$149.65 85% = \$169.60	

T2. RAI	10. TARGETTED INTRAOPERATIVI DIATION ONCOLOGY RADIOTHERAP
	Group T2. Radiation Oncology
	Subgroup 10. Targetted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiotherapy, using an Intrabeam® device delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who:
	a) is 45 years of age or more; and
	b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and
	c) has an histologic Grade 1 or 2 tumour; and
	d) has an oestrogen-receptor positive tumour; and
	e) has a node negative malignancy; and
	f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and
	g) has no contra-indications to breast irradiation
15900	Fee: \$250.00 Benefit: 75% = \$187.50
T3. THE	RAPEUTIC NUCLEAR MEDICINE
	Group T3. Therapeutic Nuclear Medicine
	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.)
	(See para TN.3.1 of explanatory notes to this Category)
16003	Fee: \$650.50 Benefit: 75% = \$487.90 85% = \$568.80
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique
16006	Fee: \$499.85 Benefit: 75% = \$374.90 85% = \$424.90
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique
6009	Fee: \$341.15 Benefit: 75% = \$255.90 85% = \$290.00
	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32
16012	Fee: \$295.15 Benefit: 75% = \$221.40 85% = \$250.90
	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either:
16015	(i) the disease is poorly controlled by conventional radiotherapy; or

T3. THERAPEUTIC NUCLEAR MEDICINE	
	(ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain
	Fee: \$4,085.70 Benefit: 75% = \$3064.30 85% = \$4004.00
	ADMINISTRATION OF ¹⁵³ SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain.
16018	Fee: \$2,442.45 Benefit: 75% = \$1831.85 85% = \$2360.75
T4. OBS	STETRICS
	Group T4. Obstetrics
	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if:
	(a) the attendance is by video conference; and
	(b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
16399	(See para TN.4.12 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 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;
16400	(c) the service is not performed in conjunction with another antenatal attendance item (same patient,

T4. OBS	STETRICS
	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 TN.4.1 of explanatory notes to this Category) Fee: \$27.25 Benefit: 85% = \$23.20 Extended Medicare Safety Net Cap: \$11.05
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each attendance, other than a second or subsequent attendance in a single course of treatment
16401	(See para TN.4.2 of explanatory notes to this Category) Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75 Extended Medicare Safety Net Cap: \$54.90
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment.
16404	(See para AN.0.70, TN.4.2 of explanatory notes to this Category) Fee: \$43.00 Benefit: 75% = \$32.25 85% = \$36.55 Extended Medicare Safety Net Cap: \$32.95
	Antenatal professional attendance, by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy
16406	Fee: \$133.95 Benefit: 75% = \$100.50 85% = \$113.90 Extended Medicare Safety Net Cap: \$108.15
	Postnatal professional attendance (other than a service to which any other item applies) if the attendance:
	(a) is by an obstetrician or general practitioner; and
	(b) is in hospital or at consulting rooms; and
	(c) is between 4 and 8 weeks after the birth; and
	(d) lasts at least 20 minutes; and
	(e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided Payable once only for a pregnancy
16407	(See para TN.4.13 of explanatory notes to this Category) Fee: \$71.70 Benefit: 75% = \$53.80 85% = \$60.95 Extended Medicare Safety Net Cap: \$46.65
	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance:
	(a) is by:
16408	(i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the

T4. OBS	4. OBSTETRICS	
	birth); or	
	(ii) an obstetrician; or	
	(iii) a general practitioner; and	
	(b) is between 1 week and 4 weeks after the birth; and	
	(c) lasts at least 20 minutes; and	
	(d) is for a patient who was privately admitted for the birth; and	
	(e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided Payable once only for a pregnancy	
	Fee: \$53.40 Benefit: 85% = \$45.40 Extended Medicare Safety Net Cap: \$34.75	
	ANTENATAL ATTENDANCE	
16500	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10 Extended Medicare Safety Net Cap: \$32.95	
	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy (See para TN.4.3, TN.4.4 of explanatory notes to this Category)	
16501	Fee: $$140.55$ Benefit: $75\% = 105.45 $85\% = 119.50 Extended Medicare Safety Net Cap: $$65.90$	
	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	
16502	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10 Extended Medicare Safety Net Cap: \$22.00	
	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance	
16505	(See para TN.4.3 of explanatory notes to this Category) Fee: \$47.15 Benefit: 75% = \$35.40 85% = \$40.10 Extended Medicare Safety Net Cap: \$22.00	
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day	
	(See para TN.4.3 of explanatory notes to this Category) Fee: $$47.15$ Benefit: $75\% = 35.40 $85\% = 40.10	
16508	Extended Medicare Safety Net Cap: \$22.00	

T4. OBS	T4. OBSTETRICS	
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance	
16509	(See para TN.4.3 of explanatory notes to this Category)Fee: $$47.15$ Benefit: $75\% = 35.40 $85\% = 40.10 Extended Medicare Safety Net Cap: $$22.00$	
	CERVIX, purse string ligation of (Anaes.)	
16511	(See para TN.4.3 of explanatory notes to this Category) Fee: \$219.95 Benefit: 75% = \$165.00 85% = \$187.00 Extended Medicare Safety Net Cap: \$109.75	
	CERVIX, removal of purse string ligature of (Anaes.)	
16512	(See para TN.4.3 of explanatory notes to this Category)Fee: \$63.50Benefit: 75% = \$47.6585% = \$54.00Extended Medicare Safety Net Cap: \$32.95	
	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)	
16514	(See para TN.4.3 of explanatory notes to this Category) Fee: \$36.65 Benefit: 75% = \$27.50 85% = \$31.20 Extended Medicare Safety Net Cap: \$16.55	
	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.)	
16515	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 85% = \$549.15 Extended Medicare Safety Net Cap: \$175.60	
	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.)	
16518	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$450.65 Benefit: 75% = \$338.00 85% = \$383.10 Extended Medicare Safety Net Cap: \$175.60	
	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)	
16519	(See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category) Fee: \$693.95 Benefit: 75% = \$520.50 85% = \$612.25 Extended Medicare Safety Net Cap: \$329.15	
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)	
16520	(See para TN.4.6, TN.4.10 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 85% = \$549.15 Extended Medicare Safety Net Cap: \$329.15	
	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days:	
16522		

T4. OBSTETRICS	
(a) fetal loss;
(b) multiple pregnancy;
(c) antepartum haemorrhage that is:
	(i) of greater than 200 ml; or
	(ii) associated with disseminated intravascular coagulation;
) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal ervical os;
(e) baby with a birth weight less than or equal to 2,500 g;
) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after resarean section;
(g) trial of vaginal breech birth where there has been a planned vaginal breech birth;
ev) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as videnced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical latation and effacement until full dilatation of the cervix);
(i)) acute fetal compromise evidenced by:
	(i) scalp pH less than 7.15; or
	(ii) scalp lactate greater than 4.0;
) acute fetal compromise evidenced by at least one of the following significant cardiotocograph onormalities:
	(i) prolonged bradycardia (less than 100 bpm for more than 2 minutes);
	(ii) absent baseline variability (less than 3 bpm);
	(iii) sinusoidal pattern;
	(iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability;
	(v) late decelerations;
(k) pregnancy induced hypertension of at least 140/90 mm Hg associated with:
	(i) at least 2+ proteinuria on urinalysis; or
	(ii) protein-creatinine ratio greater than 30 mg/mmol; or
	(iii) platelet count less than $150 \ge 10^9$ /L; or
	(iv) uric acid greater than 0.36 mmol/L;
(1)) gestational diabetes mellitus requiring at least daily blood glucose monitoring;
(n	n) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is

T4. OBST	4. OBSTETRICS	
	demonstrated by:	
	(i) the patient requiring hospitalisation; or	
	(ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or	
	(iii) the patient having a GP mental health treatment plan; or	
	(iv) the patient having a management plan prepared in accordance with item 291;	
	(n) disclosure or evidence of domestic violence;	
	(o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation:	
	(i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy;	
	(ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);	
	(iii) previous renal or liver transplant;	
	(iv) renal dialysis;	
	(v) chronic liver disease with documented oesophageal varices;	
	(vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);	
	(vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;	
	(viii) maternal height of less than 148 cm;	
	(ix) a body mass index greater than or equal to 40;	
	(x) pre-existing diabetes mellitus on medication prior to pregnancy;	
	(xi) thyrotoxicosis requiring medication;	
	(xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;	
	(xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;	
	(xiv) HIV, hepatitis B or hepatitis C carrier status positive;	
	(xv) red cell or platelet iso-immunisation;	
	(xvi) cancer with metastatic disease;	
	(xvii) illicit drug misuse during pregnancy (Anaes.)	
	(See para TN.4.7 of explanatory notes to this Category) Fee: \$1,629.35 Benefit: 75% = \$1222.05 Extended Medicare Safety Net Cap: \$438.90	
16527	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a	

T4. OB	OBSTETRICS	
	pregnancy.	
	(Anaes.)	
	(See para TN.4.8 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 85% = \$549.15 Extended Medicare Safety Net Cap: \$175.60	
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.)	
16528	(See para TN.4.8 of explanatory notes to this Category) Fee: \$630.85 Benefit: 75% = \$473.15 85% = \$549.15 Extended Medicare Safety Net Cap: \$329.15	
	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)	
16530	(See para TN.4.5 of explanatory notes to this Category) Fee: \$384.35 Benefit: 75% = \$288.30 85% = \$326.70 Extended Medicare Safety Net Cap: \$249.85	
	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.)	
16531	(See para TN.4.5, TN.4.14 of explanatory notes to this Category) Fee: \$768.70 Benefit: 75% = \$576.55 Extended Medicare Safety Net Cap: \$499.70	
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	
16533	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$105.55 Benefit: 75% = \$79.20 Extended Medicare Safety Net Cap: \$68.65	
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy	
16534	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$105.55 Benefit: 75% = \$79.20 Extended Medicare Safety Net Cap: \$68.65	
	POST-PARTUM CARE	
	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)	
16564	(See para TN.4.10 of explanatory notes to this Category) Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30 Extended Medicare Safety Net Cap: \$219.45	
16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of	

T4. OBS	STETRICS
	uterus, as an independent procedure (Anaes.)
	(See para TN.4.10 of explanatory notes to this Category) Fee: \$318.80 Benefit: 75% = \$239.10 85% = \$271.00 Extended Medicare Safety Net Cap: \$219.45
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.)
16570	(See para TN.4.10 of explanatory notes to this Category) Fee: \$416.05 Benefit: 75% = \$312.05 85% = \$353.65 Extended Medicare Safety Net Cap: \$219.45
	CERVIX, repair of extensive laceration or lacerations (Anaes.)
16571	(See para TN.4.10 of explanatory notes to this Category) Fee: \$318.80 Benefit: 75% = \$239.10 85% = \$271.00 Extended Medicare Safety Net Cap: \$219.45
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)
16573	(See para TN.4.10 of explanatory notes to this Category) Fee: \$259.80 Benefit: 75% = \$194.85 85% = \$220.85 Extended Medicare Safety Net Cap: \$219.45
	Planning and management, by a practitioner, of a pregnancy if:
	(a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and
	(b) the patient intends to be privately admitted for the birth; and
	(c) the pregnancy has progressed beyond 28 weeks gestation; and
	(d) the practitioner has maternity privileges at a hospital or birth centre; and
	(e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(f) a service to which item 16591 applies is not provided in relation to the same pregnancy
	Payable once only for a pregnancy
16590	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) Fee: \$372.75 Benefit: 75% = \$279.60 85% = \$316.85 Extended Medicare Safety Net Cap: \$219.45
	Planning and management, by a practitioner, of a pregnancy if:
	(a) the pregnancy has progressed beyond 28 weeks gestation; and
	(b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(c) a service to which item 16590 applies is not provided in relation to the same pregnancy
16591	Payable once only for a pregnancy

	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) Fee: \$142.65 Benefit: 75% = \$107.00 85% = \$121.30
	Extended Medicare Safety Net Cap: \$109.75
	INTERVENTIONAL TECHNIQUES
	AMNIOCENTESIS, diagnostic
16600	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)Fee: $$63.50$ Benefit: $75\% = 47.65 $85\% = 54.00 Extended Medicare Safety Net Cap: $$32.95$
10000	CHORIONIC VILLUS SAMPLING, by any route
16603	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: $$121.85$ Benefit: $75\% = 91.40 $85\% = 103.60 Extended Medicare Safety Net Cap: $$65.90$
	Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)
16606	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$243.25 Benefit: 75% = \$182.45 85% = \$206.80 Extended Medicare Safety Net Cap: \$131.75
1.000	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.) (See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$496.00 Benefit: 75% = \$372.00 85% = \$421.60 Extended Musclement Soft A.
16609	Extended Medicare Safety Net Cap: \$252.40
	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.)
16612	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$390.25 Benefit: 75% = \$292.70 85% = \$331.75
	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)
16615	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$207.85 Benefit: 75% = \$155.90 85% = \$176.70
	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated
16618	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$207.85 Benefit: 75% = \$155.90 85% = \$176.70 Extended Medicare Safety Net Cap: \$104.30
	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios
16621	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$207.85 Benefit: 75% = \$155.90 85% = \$176.70

	FOETAL FLUID FILLED CAVITY, drainage of
16624	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$299.10 Benefit: 75% = \$224.35 85% = \$254.25 Extended Medicare Safety Net Cap: \$142.65
	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis
16627	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$608.95 Benefit: 75% = \$456.75 85% = \$527.25 Extended Medicare Safety Net Cap: \$307.25
T6. AN/	AESTHETICS 1. ANAESTHESIA CONSULTATION
	Group T6. Anaesthetics
	Subgroup 1. Anaesthesia Consultations
	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if:
	(a) the attendance is by video conference; and
	(b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service;
	for which a direction made under subsection 19 (2) of the Act applies
	(See para TN.6.4 of explanatory notes to this Category) Derived Fee: 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or \$500.00, whichever is the less
17609	amount ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION
17610	(Professional attendance by a medical practitioner in the practice of ANAESTHESIA)

T6. ANA	T6. ANAESTHETICS 1. ANAESTHESIA CONSULTATION	
	- a BRIEF consultation involving a targeted history and limited examination (including the cardio- respiratory system)	
	- AND of not more than 15 minutes s duration, not being a service associated with a service to which items 2801 - 3000 apply	
	(See para TN.6.1 of explanatory notes to this Category) Fee: $$43.00$ Benefit: $75\% = 32.25 $85\% = 36.55 Extended Medicare Safety Net Cap: $$129.00$	
	 a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes 	
	- AND of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 applies	
17615	(See para TN.6.1 of explanatory notes to this Category)Fee: $\$85.55$ Benefit: $75\% = \$64.20$ $85\% = \$72.75$ Extended Medicare Safety Net Cap: $\$256.65$	
	- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes	
	- AND of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	
17620	(See para TN.6.1 of explanatory notes to this Category) Fee: \$118.50 Benefit: 75% = \$88.90 85% = \$100.75 Extended Medicare Safety Net Cap: \$355.50	
	- 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	
	- AND of more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply	
17625	(See para TN.6.1 of explanatory notes to this Category)Fee: $$150.90$ Benefit: $75\% = 113.20 $85\% = 128.30 Extended Medicare Safety Net Cap: $$452.70$	
	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)	
17640		

T6. ANAESTHETICS 1. ANAESTHESIA CON		1. ANAESTHESIA CONSULTATIONS
	(Professional attendance by a specialist anaesthetist in the prise referred to him or her)	actice of ANAESTHESIA where the patient
	- a BRIEF consultation involving a short history and limite	d examination
	- AND of not more than 15 minutes duration, not being a s items 2801 - 3000 apply	service associated with a service to which
	(See para TN.6.2 of explanatory notes to this Category) Fee: \$43.00 Benefit: 75% = \$32.25 85% = \$36.55 Extended Medicare Safety Net Cap: \$129.00	
	- a consultation involving a selective history and examinati of a written patient management plan	on of multiple systems and the formulation
	- AND of more than 15 minutes but not more than 30 minutes with a service to which items 2801 - 3000 apply.	tes duration, not being a service associated
17645	(See para TN.6.2 of explanatory notes to this Category) Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75 Extended Medicare Safety Net Cap: \$256.65	
	- a consultation involving a detailed history and compreher the formulation of a written patient management plan	nsive examination of multiple systems and
	- AND of more than 30 minutes but not more than 45 minutes with a service to which items 2801 - 3000 apply	tes duration, not being a service associated
17650	(See para TN.6.2 of explanatory notes to this Category) Fee: \$118.50 Benefit: 75% = \$88.90 85% = \$100.75 Extended Medicare Safety Net Cap: \$355.50	
	- a consultation involving an exhaustive history and compr and the formulation of a written patient management plan for professionals and/or the patient, involving medical planning	llowing discussion with relevant health care
	- AND of more than 45 minutes duration, not being a service 2801 - 3000 apply.	ce associated with a service to which items
17655	(See para TN.6.2 of explanatory notes to this Category) Fee: \$150.90 Benefit: 75% = \$113.20 85% = \$128.30 Extended Medicare Safety Net Cap: \$452.70	
	ANAESTHETIST, CONSULTA	ATION, OTHER
17680		

T6. ANAESTHETICS 1. ANAESTHESIA CONSULTAT	
	(Professional attendance by an anaesthetist in the practice of ANAESTHESIA)
	- a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 - 3000 apply.
	(See para TN.6.3 of explanatory notes to this Category) Fee: \$85.55 Benefit: 75% = \$64.20 85% = \$72.75 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:
	(a) the service is provided to a patient prior to an admitted patient episode of care involving anaesthesia; and
	(b) the service is not provided to an admitted patient of a hospital; and
	(c) the service is not provided on the day of admission to hospital for the subsequent episode of care involving anaesthesia services; and
	(d) the service is of more than 15 minutes duration
	not being a service associated with a service to which items 2801 - 3000 apply.
17690	(See para TN.6.3 of explanatory notes to this Category) Fee: \$39.55 Benefit: 75% = \$29.70 85% = \$33.65 Extended Medicare Safety Net Cap: \$118.65
T7. REG	GIONAL OR FIELD NERVE BLOCKS
	Group T7. Regional Or Field Nerve Blocks
	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion
18213	Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40
	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.)
18216	Fee: \$189.90 Benefit: 75% = \$142.45 85% = \$161.45
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

T7. REC	GIONAL OR FIELD NERVE BLOCKS	
	hour (Anaes.)	
	Derived Fee: The fee for item 18216 plus \$19.00 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.	
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less	
18222	(See para TN.7.2 of explanatory notes to this Category)Fee: $$37.65$ Benefit: $75\% = 28.25 $85\% = 32.05	
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes	
18225	(See para TN.7.2 of explanatory notes to this Category) Benefit: $75\% = 37.55 $85\% = 42.55	
	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.	
18226	(See para TN.7.4 of explanatory notes to this Category) Fee: \$284.80 Benefit: 75% = \$213.60 85% = \$242.10	
	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday.	
18227	(See para TN.7.4 of explanatory notes to this Category) Derived Fee: The fee for item 18226 plus \$28.60 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.	
	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance	
18228	Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15	
	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)	
18230	Fee: \$238.45 Benefit: 75% = \$178.85 85% = \$202.70	
	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.)	
18232	(See para TN.7.3 of explanatory notes to this Category) Fee: \$189.90 Benefit: 75% = \$142.45 85% = \$161.45	
	EPIDURAL INJECTION of blood for blood patch (Anaes.)	
18233	Fee: \$189.90 Benefit: 75% = \$142.45 85% = \$161.45	
	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)	
18234	(See para TN.7.5 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15	
	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)	
18236	(See para TN.7.5 of explanatory notes to this Category)	

T7. REC	GIONAL OR FIELD NERVE BLOCKS
	Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15
	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies
18238	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$37.65$ Benefit: $75\% = \$28.25$ $85\% = \$32.05$
	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent
18240	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$93.60$ Benefit: $75\% = \$70.20$ $85\% = \$79.60$
	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)
18242	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$37.65$ Benefit: $75\% = \$28.25$ $85\% = \$32.05$
	VAGUS NERVE, injection of an anaesthetic agent
18244	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$100.80$ Benefit: $75\% = \$75.60$ $\$5\% = \85.70
	PHRENIC NERVE, injection of an anaesthetic agent
18248	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$88.65$ Benefit: $75\% = \$66.50$ $\$5\% = \75.40
	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent
18250	(See para TN.7.5 of explanatory notes to this Category)Fee: $$62.50$ Benefit: $75\% = 46.90 $85\% = 53.15
	CERVICAL PLEXUS, injection of an anaesthetic agent
	(See para TN.7.5 of explanatory notes to this Category)
18252	Fee: \$100.80 Benefit: 75% = \$75.60 85% = \$85.70 DDACHIAL DEEXLIS injection of an anagethetic agent
	BRACHIAL PLEXUS, injection of an anaesthetic agent
18254	(See para TN.7.5 of explanatory notes to this Category) Fee: $$100.80$ Benefit: $75\% = 75.60 $85\% = 85.70
	SUPRASCAPULAR NERVE, injection of an anaesthetic agent
	(See para TN.7.5 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
18258	(See para TN.7.5 of explanatory notes to this Category)Fee: $$62.50$ Benefit: $75\% = 46.90 $85\% = 53.15
	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent
18260	(See para TN.7.5 of explanatory notes to this Category)Fee: $\$88.65$ Benefit: $75\% = \$66.50$ $\$5\% = \75.40
	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.)
	(See para TN.7.5 of explanatory notes to this Category)
18262	Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15

T7. REC	IONAL OR FIELD NERVE BLOCKS
	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent
18264	(See para TN.7.5 of explanatory notes to this Category) 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
18266	(See para TN.7.5 of explanatory notes to this Category) Fee: \$62.50 Benefit: 75% = \$46.90 85% = \$53.15
	OBTURATOR NERVE, injection of an anaesthetic agent
18268	(See para TN.7.5 of explanatory notes to this Category) Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40
	FEMORAL NERVE, injection of an anaesthetic agent
18270	(See para TN.7.5 of explanatory notes to this Category) 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
18272	(See para TN.7.5 of explanatory notes to this Category)Fee: $$62.50$ Benefit: $75\% = 46.90 $85\% = 53.15
	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)
18274	(See para TN.7.5 of explanatory notes to this Category) Fee: \$88.65 Benefit: 75% = \$66.50 85% = \$75.40
	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)
18276	(See para TN.7.5 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15
18270	SCIATIC NERVE, injection of an anaesthetic agent
18278	(See para TN.7.5 of explanatory notes to this Category) Fee: $\$88.65$ Benefit: $75\% = \$66.50$ $\$5\% = \75.40
	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.)
18280	(See para TN.7.5 of explanatory notes to this Category) Fee: \$124.85 Benefit: 75% = \$93.65 85% = \$106.15
	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure
18282	(See para TN.7.5 of explanatory notes to this Category)Fee: $$100.80$ Benefit: $75\% = 75.60 $85\% = 85.70
	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)
18284	(See para TN.7.5 of explanatory notes to this Category)Fee: $$147.65$ Benefit: $75\% = 110.75 $85\% = 125.55
_	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)
	(See para TN.7.5 of explanatory notes to this Category)
18286	Fee: \$147.65 Benefit: 75% = \$110.75 85% = \$125.55

17. REC	BIONAL OR FIEL	D NERVE BLOCKS
	COELIAC PLE	XUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)
	(See para TN.7.5	of explanatory notes to this Category)
18288	Fee: \$147.65	Benefit: 75% = \$110.75 85% = \$125.55
		RVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a ed with the injection of botulinum toxin (Anaes.)
18290	Fee: \$249.75	Benefit: 75% = \$187.35 85% = \$212.30
	Group applies o	CH, destruction by a neurolytic agent, not being a service to which any other item in this r a service associated with the injection of botulinum toxin except those services to 54 applies (Anaes.)
18292	(See para TN.7.5 Fee: \$124.85	of explanatory notes to this Category) Benefit: 75% = \$93.65 85% = \$106.15
	COELIAC PLE	XUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)
18294	Fee: \$176.00	Benefit: 75% = \$132.00 85% = \$149.60
	LUMBAR SYN	IPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)
18296	Fee: \$150.55	Benefit: 75% = \$112.95 85% = \$128.00
	CERVICAL OF	R THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)
18298	Fee: \$176.00	Benefit: 75% = \$132.00 85% = \$149.60
T8. SUF	RGICAL OPERAT	TIONS 1. GENERAL
	Group T8. Surg	gical Operations
		Subgroup 1. General
		ROCEDURE, not being a service to which any other item in this Group applies, being a a nan item in this Group would have applied had the procedure not been discontinued on s
30001		of explanatory notes to this Category) 0% of the fee which would have applied had the procedure not been discontinued
	LOCALISED B	URNS, dressing of, (not involving grafting) each attendance at which the procedure is using any associated consultation
30003	Fee: \$36.30	Benefit: 75% = \$27.25 85% = \$30.90
30003	EXTENSIVE B	Benefit: 75% = \$27.25 85% = \$30.90 URNS, dressing of, without anaesthesia (not involving grafting) each attendance at dure is performed, including any associated consultation
30003 30006	EXTENSIVE B	URNS, dressing of, without anaesthesia (not involving grafting) each attendance at
	EXTENSIVE B which the proce Fee: \$46.50	URNS, dressing of, without anaesthesia (not involving grafting) each attendance at dure is performed, including any associated consultation
	EXTENSIVE B which the proce Fee: \$46.50	URNS, dressing of, without anaesthesia (not involving grafting) each attendance at dure is performed, including any associated consultation Benefit: 75% = \$34.90 85% = \$39.55
30006	EXTENSIVE B which the proce Fee: \$46.50 LOCALISED B Fee: \$73.90	URNS, dressing of, without anaesthesia (not involving grafting) each attendance at dure is performed, including any associated consultation Benefit: 75% = \$34.90 85% = \$39.55 URNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)
30006	EXTENSIVE B which the proce Fee: \$46.50 LOCALISED B Fee: \$73.90	URNS, dressing of, without anaesthesia (not involving grafting) each attendance at dure is performed, including any associated consultation Benefit: 75% = \$34.90 85% = \$39.55 URNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) Benefit: 75% = \$55.45

T8. SUF	RGICAL OPERATI	ONS	1. GENERAL
	Fee: \$326.05	Benefit: 75% = \$244.55 85% = \$277.15	
		n of, under general anaesthesia, involving more than 10 per cen rried out during the same operation (Anaes.) (Assist.)	t of body surface, where
30020	Fee: \$635.00	Benefit: 75% = \$476.25	
		FT TISSUE, traumatic, deep or extensively contaminated, debisia or regional or field nerve block, including suturing of that w	
30023	(See para TN.8.6 of Fee: \$326.05	f explanatory notes to this Category) Benefit: 75% = \$244.55 85% = \$277.15	
	Gangrene, under	FT TISSUE, debridement of extensively infected post-surgical general anaesthesia or regional or field nerve block, including (Anaes.) (Assist.)	
30024	Fee: \$326.05	Benefit: 75% = \$244.55 85% = \$277.15	
	other than wound	CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA l closure at time of surgery, not on face or neck, small (NOT M ial, not being a service to which another item in Group T4 appl	IORE THAN 7 CM
30026	(See para TN.8.6 of Fee: \$52.20	f explanatory notes to this Category) Benefit: $75\% = 39.15 $85\% = 44.40	
	other than wound	CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA l closure at time of surgery, not on face or neck, small (NOT M g deeper tissue, not being a service to which another item in G	IORE THAN 7 CM
30029	(See para TN.8.6 of Fee: \$90.00	f explanatory notes to this Category) Benefit: $75\% = 67.50 $85\% = 76.50	
		CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA closure at time of surgery, on face or neck, small (NOT MOR s.)	
30032	(See para TN.8.6 of Fee: \$82.50	f explanatory notes to this Category) Benefit: 75% = \$61.90 85% = \$70.15	
		CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA closure at time of surgery, on face or neck, small (NOT MOR tissue (Anaes.)	
30035	(See para TN.8.6 of Fee: \$117.55	f explanatory notes to this Category) Benefit: 75% = \$88.20 85% = \$99.95	
	other than wound	CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA l closure at time of surgery, not on face or neck, large (MORE ' eing a service to which another item in Group T4 applies (Anac	THAN 7 CM LONG),
30038	(See para TN.8.6 of Fee: \$90.00	f explanatory notes to this Category) Benefit: 75% = \$67.50 85% = \$76.50	
	other than wound	CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA l closure at time of surgery, other than on face or neck, large (M g deeper tissue, other than a service to which another item in C	IORE THAN 7 CM
30042	(See para TN.8.6 of	f explanatory notes to this Category)	

T8. SUR	GICAL OPERAT	ONS	1. GENERAL
	Fee: \$185.60	Benefit: 75% = \$139.20 85% = \$157.80	
		CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIL closure at time of surgery, on face or neck, large (MORE THA s.)	
30045	(See para TN.8.6 o Fee: \$117.55	f explanatory notes to this Category) Benefit: 75% = \$88.20 85% = \$99.95	
		CUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIL closure at time of surgery, on face or neck, large (MORE THA tissue (Anaes.)	
30049	(See para TN.8.6 o Fee: \$185.60	f explanatory notes to this Category) Benefit: 75% = \$139.20 85% = \$157.80	
		ESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair h layer of tissue (Anaes.) (Assist.)	of, with accurate
30052	Fee: \$254.00	Benefit: 75% = \$190.50 85% = \$215.90	
		SSING OF, under general anaesthesia, with or without removal d with a service to which another item in this Group applies (An	
30055	Fee: \$73.90	Benefit: 75% = \$55.45 85% = \$62.85	
	POSTOPERATI procedure (Anaes	VE HAEMORRHAGE, control of, under general anaesthesia, as s.)	s an independent
30058	Fee: \$144.35	Benefit: 75% = \$108.30 85% = \$122.70	
	SUPERFICIAL I independent proc	FOREIGN BODY, REMOVAL OF, (including from cornea or s edure (Anaes.)	sclera), as an
30061	Fee: \$23.50	Benefit: 75% = \$17.65 85% = \$20.00	
	Etonogestrel sub	cutaneous implant, removal of, as an independent procedure (Ar	naes.)
30062	Fee: \$60.75	Benefit: 75% = \$45.60 85% = \$51.65	
		US FOREIGN BODY, removal of, requiring incision and exploremed, as an independent procedure (Anaes.)	ration, including closure
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.)		
30068	Fee: \$276.80	Benefit: 75% = \$207.60 85% = \$235.30	
	Diagnostic biops examination (An	y of skin, as an independent procedure, if the biopsy specimen is aes.)	s sent for pathological
30071	Fee: \$52.20	f explanatory notes to this Category) Benefit: 75% = \$39.15 85% = \$44.40 Fare Safety Net Cap: \$41.80	
	Diagnostic biops	y of mucous membrane, as an independent procedure, if the biop nination (Anaes.)	psy specimen is sent for
30072	(See para TN.8.7 o Fee: \$52.20	f explanatory notes to this Category) Benefit: 75% = \$39.15 85% = \$44.40	

T8. SUF	GICAL OPERATIONS	1. GENERAL
	DIAGNOSTIC BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP ' an independent procedure, if the biopsy specimen is sent for pathological exami	
30075	Fee: \$149.75 Benefit: 75% = \$112.35 85% = \$127.30	
	DIAGNOSTIC DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR OR procedure, where the biopsy specimen is sent for pathological examination (An	· .
30078	(See para TN.8.7 of explanatory notes to this Category) Fee: \$48.45 Benefit: 75% = \$36.35 85% = \$41.20	
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approac specimen is sent for pathological examination (Anaes.)	ch, where the biopsy
30081	(See para TN.8.7 of explanatory notes to this Category) Fee: \$109.90 Benefit: 75% = \$82.45 85% = \$93.45	
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous biopsy is sent for pathological examination (Anaes.)	approach where the
30084	(See para TN.8.2, TN.8.7 of explanatory notes to this Category) Fee: \$58.80 Benefit: 75% = \$44.10 85% = \$50.00	
	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOP MEMBRANE, where the biopsy is sent for pathological examination (Anaes.)	SY OF SYNOVIAL
30087	(See para TN.8.7 of explanatory notes to this Category) Fee: \$29.45 Benefit: 75% = \$22.10 85% = \$25.05	
	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies the biopsy is sent for pathological examination (Anaes.)	on any 1 occasion, where
30090	(See para TN.8.7 of explanatory notes to this Category) Fee: \$128.55 Benefit: 75% = \$96.45 85% = \$109.30	
	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent feet a camination (Anaes.)	or pathological
30093	(See para TN.8.7 of explanatory notes to this Category) Fee: \$171.55 Benefit: 75% = \$128.70 85% = \$145.85	
	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ usin techniques - but not including imaging, where the biopsy is sent for pathological	
30094	(See para TN.8.7 of explanatory notes to this Category) Fee: \$189.40 Benefit: 75% = \$142.05 85% = \$161.00	
	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the spec pathological examination (Anaes.)	cimen excised is sent for
30096	(See para TN.8.7 of explanatory notes to this Category) Fee: \$183.90 Benefit: 75% = \$137.95 85% = \$156.35	
	Personal performance of a Synacthen Stimulation Test, including associated con practitioner with resuscitation training and access to facilities where life suppor 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	

T8. SUF	GICAL OPERAT	IONS	1. GENERAL
	SINUS, excision	of, involving muscle and deep tissue (Anaes.)	
30103	Fee: \$183.90	Benefit: 75% = \$137.95 85% = \$156.35	
	PRE-AURICUL	AR SINUS, on a person 10 years of age or over. Excision of,	(Anaes.)
30104	Fee: \$126.90	Benefit: 75% = \$95.20 85% = \$107.90	
	PRE-AURICUL	AR SINUS, on a person under 10 years of age. Excision of, (A	Anaes.)
30105	Fee: \$164.95	Benefit: 75% = \$123.75 85% = \$140.25	
		R SMALL BURSA, excision of, other than a service associated his Group applies (Anaes.)	l with a service to which
30107	Fee: \$219.95	Benefit: 75% = \$165.00 85% = \$187.00	
	BURSA (LARG (Assist.)	E), INCLUDING OLECRANON, CALCANEUM OR PATEI	LLA, excision of (Anaes.)
30111	Fee: \$371.50	Benefit: 75% = \$278.65 85% = \$315.80	
	BURSA, SEMIN	MEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.)
30114	Fee: \$371.50	Benefit: 75% = \$278.65	
30165	 45530, 45564 or (a) there is interticonventional (or (b) the abdomination (c) the weight halipectomy (H) (Anaes.) (As (See para TN.8.8 or 	of explanatory notes to this Category)	nd has failed 3 months of
	Fee: \$454.85Benefit: 75% = \$341.15Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months o conventional (or non surgical) treatment; and(b) the redundant skin and fat interferes with the activities of daily living; and(c) the weight has been stable for at least 6 months following significant weight loss prior to the 		item 30165, 30171, nd has failed 3 months of
30168	(See para TN.8.8 c	of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	Fee: \$454.85 Benefit: 75% = \$341.15	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consignificant weight loss, not being a service associated with a service to which item 301 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has conventional (or non surgical) treatment; and	failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss palipectomy; and	rior to the
	(d) the procedure involves 2 excisions only	
	(H) (Anaes.) (Assist.)	
30171	(See para TN.8.8 of explanatory notes to this Category) Fee: \$691.75 Benefit: 75% = \$518.85	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct co significant weight loss, not being a service associated with a service to which item 301 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has conventional (or non surgical) treatment; and	failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss palipectomy; and	rior to the
	(d) the procedure involves 3 or more excisions	
	(H) (Anaes.) (Assist.)	
30172	(See para TN.8.8 of explanatory notes to this Category) Fee: \$691.75 Benefit: 75% = \$518.85	
	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin at tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 4556 applies, if it can be demonstrated that there is an anterior abdominal wall defect that is the surgical removal of large intra abdominal or pelvic tumours	service associated 4 or 45565
	(H) (Anaes.) (Assist.)	
30176	(See para TN.8.8 of explanatory notes to this Category) Fee: \$985.70 Benefit: 75% = \$739.30	
	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdom that is a direct consequence of significant weight loss, in conjunction with a radical ab (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and tran umbilicus, not being a service associated with a service to which item 30165, 30168, 3 30176, 30179, 45530, 45564 or 45565 applies, if:	dominoplasty sposition of
30177	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has	failed 3 months of

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	conventional (or non surgical) treatment; and	
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prid lipectomy	or to the
	(H) (Anaes.) (Assist.)	
	(See para TN.8.8 of explanatory notes to this Category) Fee: \$985.70 Benefit: 75% = \$739.30	
	Circumferential lipectomy, as an independent procedure, to correct circumferential exce skin and fat that is a direct consequence of significant weight loss, with or without a rad abdominoplasty (Pitanguy type or similar), not being a service associated with a service 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if:	ical
	(a) the circumferential excess of redundant skin and fat is complicated by intertrigo or a condition that risks loss of skin integrity and has failed 3 months of conventional (or not treatment; and	
	(b) the circumferential excess of redundant skin and fat interferes with the activities of c	laily living; and
	(c) the weight has been stable for at least 6 months following significant weight loss prid lipectomy	or to the
	(H) (Anaes.) (Assist.)	
30179	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,213.15 Benefit: 75% = \$909.90	
	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.)	
30180	Fee: \$136.50 Benefit: 75% = \$102.40 85% = \$116.05	
	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.)	
30183	Fee: \$246.50 Benefit: 75% = \$184.90 85% = \$209.55	
	PALMAR OR PLANTAR WARTS (10 or more), definitive removal of, excluding ablat alone, not being a service to which item 30186 or 30187 applies (Anaes.)	tive methods
30185	(See para TN.8.9 of explanatory notes to this Category) Fee: \$182.50 Benefit: 75% = \$136.90 85% = \$155.15	
	PALMAR OR PLANTAR WARTS (less than 10), definitive removal of, excluding abla alone, not being a service to which item 30185 or 30187 applies (Anaes.)	ative methods
30186	(See para TN.8.9 of explanatory notes to this Category) Fee: \$47.45 Benefit: 75% = \$35.60 85% = \$40.35	
	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser admission to a hospital, or when performed by a specialist in the practice of his/her spec warts) (Anaes.)	
30187	(See para TN.8.9 of explanatory notes to this Category) Fee: \$256.95 Benefit: 75% = \$192.75 85% = \$218.45	
30189	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method chemical means), where undertaken in the operating theatre of a hospital, not being a set	

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	with a service to which another item in this Group applies (H) (Anaes.)
	(See para TN.8.9 of explanatory notes to this Category) Fee: \$147.30 Benefit: 75% = \$110.50
	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.)
30190	Fee: \$397.75 Benefit: 75% = \$298.35 85% = \$338.10
	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)
30192	(See para TN.8.9 of explanatory notes to this Category)Fee: $\$39.55$ Benefit: $75\% = \$29.70$ $85\% = \$33.65$
	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.)
30195	(See para TN.8.9 of explanatory notes to this Category) Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00
	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.)
30196	(See para TN.8.10 of explanatory notes to this Category)Fee: $$126.30$ Benefit: $75\% = 94.75 $85\% = 107.40
	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 OR MORE LESIONS) (Anaes.)
30197	(See para TN.8.10 of explanatory notes to this Category) Fee: \$440.05 Benefit: 75% = \$330.05 85% = \$374.05
	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
30202	(See para TN.8.10 of explanatory notes to this Category) Fee: \$48.35 Benefit: 75% = \$36.30 85% = \$41.10
	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)
30203	(See para TN.8.10 of explanatory notes to this Category)Fee: $\$170.25$ Benefit: $75\% = \$127.70$ $85\% = \$144.75$
	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.)
30205	Fee: \$126.30 Benefit: 75% = \$94.75 85% = \$107.40

T8. SUR	RGICAL OPERATIONS	1. GENERAL
	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (A	Anaes.)
30207	Fee: \$44.60 Benefit: 75% = \$33.45 85% = \$37.95	
	KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating the (Anaes.)	
30210	Fee: \$162.95 Benefit: 75% = \$122.25	
	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesi metres, diathermy or sclerosant injection of, including associated consultation - lim 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply period - for a session of at least 20 minutes duration (Anaes.)	ited to a maximum of
30213	(See para TN.8.11 of explanatory notes to this Category) Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35	
	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesi metres, diathermy or sclerosant injection of, including associated consultation - <u>ses</u> <u>minutes duration</u> - where it can be demonstrated that a 7th or subsequent session (i to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period (See para TN.8.11 of explanatory notes to this Category)	sion of at least 20 including any sessions
30214	Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35	
	HAEMATOMA, aspiration of (Anaes.)	
30216	Fee: \$27.35 Benefit: 75% = \$20.55 85% = \$23.25	
	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not re a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)	quiring admission to
30219	(See para TN.8.4 of explanatory notes to this Category) Fee: \$27.35 Benefit: 75% = \$20.55 85% = \$23.25	
	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or si requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding at	
30223	(See para TN.8.4 of explanatory notes to this Category) Fee: \$162.95 Benefit: 75% = \$122.25	
	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imagin not including imaging (Anaes.)	ng techniques - but
30224	Fee: \$237.60 Benefit: 75% = \$178.20 85% = \$202.00	
	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniqu imaging (Anaes.)	es - but not including
30225	Fee: \$267.65 Benefit: 75% = \$200.75 85% = \$227.55	
	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.)	
30226	Fee: \$149.75 Benefit: 75% = \$112.35 85% = \$127.30	
	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.)	
30229	Fee: \$272.95 Benefit: 75% = \$204.75 85% = \$232.05	
55229	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (A	.naes.)
20222		
30232	Fee: \$223.60 Benefit: 75% = \$167.70 85% = \$190.10	

T8. SUF	RGICAL OPERATI	ONS	1. GENERAL
	MUSCLE, RUPT	URED, repair of (extensive), not associated with external wound (Anaes	.) (Assist.)
30235	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35	
	FASCIA, DEEP,	repair of, FOR HERNIATED MUSCLE (Anaes.)	
30238	Fee: \$149.75	Benefit: 75% = \$112.35 85% = \$127.30	
	BONE TUMOUF applies (Anaes.) (R, INNOCENT, excision of, not being a service to which another item in (Assist.)	this Group
30241	Fee: \$356.35	Benefit: 75% = \$267.30 85% = \$302.90	
	STYLOID PROC	ESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)	
30244	Fee: \$356.35	Benefit: 75% = \$267.30	
	PAROTID DUCT	Γ, repair of, using micro-surgical techniques (Anaes.) (Assist.)	
30246	Fee: \$689.80	Benefit: 75% = \$517.35	
		ND, total extirpation of (Anaes.) (Assist.)	
30247	Fee: \$739.35	Benefit: 75% = \$554.55	
		ND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist	.)
30250	Fee: \$1,251.10	Benefit: 75% = \$938.35	
50250		AROTID TUMOUR, excision of, with preservation of facial nerve (Anae	es.) (Assist.)
30251	Fee: \$1,921.75	Benefit: 75% = \$1441.35 85% = \$1840.05	, , ,
30231		ND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (A	(naes.)
	(Assist.)	,	
30253	Fee: \$834.05	Benefit: 75% = \$625.55	
	SUBMANDIBUI	LAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Ass	sist.)
30255	Fee: \$1,110.65	Benefit: 75% = \$833.00	
		LAR GLAND, extirpation of (Anaes.) (Assist.)	
30256	Fee: \$445.40	Benefit: 75% = \$334.05	
		GLAND, extirpation of (Anaes.)	
30259	Fee: \$198.50	Benefit: 75% = \$148.90 85% = \$168.75	
30237		AND, DILATATION OR DIATHERMY of duct (Anaes.)	
30262	Fee: \$58.80	Benefit: 75% = \$44.10 85% = \$50.00	
30202		moval of calculus from duct or meatotomy or marsupialisation, 1 or more	e such
30266	Fee: \$149.75	Benefit: 75% = \$112.35 85% = \$127.30	
		AND, repair of CUTANEOUS FISTULA OF (Anaes.)	
30269	Fee: \$149.75	Benefit: 75% = \$112.35 85% = \$127.30	
20202		l excision of (Anaes.) (Assist.)	
30272	· •		

T8. SUF	RGICAL OPERATI	ONS	1. GENERAL
	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35	
		ISION OF INTRAORAL TUMOUR INVOLVING RESECTION (LANDS OF NECK (commandotype operation) (Anaes.) (Assist.)	OF MANDIBLE
30275	Fee: \$1,762.75	Benefit: 75% = \$1322.10	
	TONGUE TIE, re	epair of, not being a service to which another item in this Group ap	plies (Anaes.)
30278	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55	
		ANDIBULAR FRENULUM or MAXILLARY FRENULUM, repover, under general anaesthesia (Anaes.)	pair of, in a person
30281	Fee: \$119.50	Benefit: 75% = \$89.65 85% = \$101.60	
	RANULA OR M	UCOUS CYST OF MOUTH, removal of (Anaes.)	
30283	Fee: \$204.70	Benefit: 75% = \$153.55 85% = \$174.00	
	BRANCHIAL C	YST, on a person 10 years of age or over. Removal of, (Anaes.) (A	Assist.)
30286	Fee: \$397.85	Benefit: 75% = \$298.40 85% = \$338.20	
	BRANCHIAL C	YST, on a person under 10 years of age. Removal of, (Anaes.) (As	ssist.)
30287	Fee: \$517.20	Benefit: 75% = \$387.90 85% = \$439.65	
	BRANCHIAL FI	STULA, on a person 10 years of age or over. Removal of, (Anaes	.) (Assist.)
30289	Fee: \$502.25	Benefit: 75% = \$376.70	
		SOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGO pair (Anaes.) (Assist.)	STOMY with or
30293	Fee: \$445.40	Benefit: 75% = \$334.05 85% = \$378.60	
		SOPHAGECTOMY with tracheostomy and oesophagostomy, with r LARYNGOPHARYNGECTOMY with tracheostomy and plastic	
30294	Fee: \$1,762.75	Benefit: 75% = \$1322.10	
	THYROIDECTC	DMY, total (Anaes.) (Assist.)	
30296	Fee: \$1,023.70	Benefit: 75% = \$767.80	
	THYROIDECTC	OMY following previous thyroid surgery (Anaes.) (Assist.)	
30297	Fee: \$1,023.70	Benefit: 75% = \$767.80	
	axilla, using preo	APH NODE BIOPSY OR BIOPSIES for breast cancer, involving d perative lymphoscintigraphy and lymphotropic dye injection, not b service to which item 30300, 30302 or 30303 applies (Anaes.) (As	being a service
30299	(See para TN.8.12 Fee: \$637.45	of explanatory notes to this Category) Benefit: 75% = \$478.10	
	II/III axilla, using	APH NODE BIOPSY OR BIOPSIES for breast cancer, involving d g preoperative lymphoscintigraphy and lymphotropic dye injection, service to which item 30299, 30302 or 30303 applies (Anaes.) (As	, not being a service
30300	(See para TN.8.12 Fee: \$764.90	of explanatory notes to this Category) Benefit: 75% = \$573.70	

T8. SUR	GICAL OPERATION	DNS	1. GENERAL
	axilla, using lymp	PH NODE BIOPSY OR BIOPSIES for breast cancer, invol- hotropic dye injection, not being a service associated with a 0303 applies (Anaes.) (Assist.)	0
30302	(See para TN.8.12 o Fee: \$509.95	f explanatory notes to this Category) Benefit: 75% = \$382.50	
	II/III axilla, using	PH NODE BIOPSY OR BIOPSIES for breast cancer, invol- lymphotropic dye injection, not being a service associated v) or 30302 applies (Anaes.) (Assist.)	
30303	(See para TN.8.12 o Fee: \$611.85	f explanatory notes to this Category) Benefit: 75% = \$458.90	
	TOTAL HEMITH	YROIDECTOMY (Anaes.) (Assist.)	
30306	Fee: \$798.65	Benefit: 75% = \$599.00	
	BILATERAL SUI	BTOTAL THYROIDECTOMY (Anaes.) (Assist.)	
30308	Fee: \$798.65	Benefit: 75% = \$599.00	
	THYROIDECTO	MY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assis	st.)
30309	Fee: \$1,023.70	Benefit: 75% = \$767.80	
	THYROID, unilat	eral subtotal thyroidectomy or equivalent partial thyroidector	omy (Anaes.) (Assist.)
30310	Fee: \$457.40	Benefit: 75% = \$343.05	
	THYROGLOSSA	L CYST, removal of (Anaes.) (Assist.)	
30313	Fee: \$272.95	Benefit: 75% = \$204.75 85% = \$232.05	
		L CYST or FISTULA or both, on a person 10 years of age of opplossal duct and portion of hyoid bone (Anaes.) (Assist.)	or over. Radical removal
30314	Fee: \$457.40	Benefit: 75% = \$343.05	
	PARATHYROID	operation for hyperparathyroidism (Anaes.) (Assist.)	
30315	Fee: \$1,139.90	Benefit: 75% = \$854.95	
	CERVICAL REE	XPLORATION for recurrent or persistent hyperparathyroid	ism (Anaes.) (Assist.)
30317	Fee: \$1,364.90	Benefit: 75% = \$1023.70	
	MEDIASTINUM, thymectomy) (Ana	exploration of, via the cervical route, for hyperparathyroidiaes.) (Assist.)	ism (including
30318	Fee: \$907.60	Benefit: 75% = \$680.70	
	MEDIASTINUM, (Anaes.) (Assist.)	exploration of, via mediastinotomy, for hyperparathyroidis	m (including thymectomy)
30320	Fee: \$1,364.90	Benefit: 75% = \$1023.70	
	RETROPERITON	EAL NEUROENDOCRINE TUMOUR, removal of (Anae	s.) (Assist.)
30321	Fee: \$907.60	Benefit: 75% = \$680.70	
	RETROPERITON dissection (Anaes.	EAL NEUROENDOCRINE TUMOUR, removal of, requir (Assist.)	ring complex and extensive

T8. SUF	RGICAL OPERATIONS		1. GENERAL		
	Fee: \$1,364.90	Benefit: 75% = \$1023.70			
	ADRENAL GLA	ND TUMOUR, excision of (Anaes.) (Assist.)			
30324	Fee: \$1,364.90	Benefit: 75% = \$1023.70			
		AL CYST or FISTULA or both, radical removal of, including thyropone, on a person under 10 years of age (Anaes.) (Assist.)	oglossal duct and		
30326	Fee: \$594.60	Benefit: 75% = \$445.95			
	LYMPH GLAND	OS of GROIN, limited excision of (Anaes.)			
30329	Fee: \$246.95	Benefit: 75% = \$185.25 85% = \$209.95			
	LYMPH GLAND	OS of GROIN, radical excision of (Anaes.) (Assist.)			
30330	Fee: \$718.75	Benefit: 75% = \$539.10			
		of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)			
30332	Fee: \$346.75	Benefit: 75% = \$260.10			
50552		of AXILLA, complete excision of, to level I (Anaes.) (Assist.)			
	(See para TN 8-13 c	of explanatory notes to this Category)			
30335	Fee: \$866.85	Benefit: 75% = \$650.15			
	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.)				
	(See para TN.8.13 c	of explanatory notes to this Category)			
30336	Fee: \$1,040.25	Benefit: 75% = \$780.20			
	LAPAROTOMY is performed (Ana	(exploratory), including associated biopsies, where no other intra- aes.) (Assist.)	abdominal procedure		
30373	Fee: \$483.25	Benefit: 75% = \$362.45			
	Gastrotomy, on a diverticulum, Sut	erostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, C person 10 years of age or over. Reduction of intussusception, Rem ure of perforated peptic ulcer, Simple repair of ruptured viscus, Re lt) or Drainage of pancreas (Anaes.) (Assist.)	noval of Meckel's		
30375	(See para TN.8.14 o Fee: \$521.25	of explanatory notes to this Category) Benefit: 75% = \$390.95			
		INVOLVING DIVISION OF PERITONEAL ADHESIONS (whe cocedure is performed) on a person 10 years of age or over (Anaes.			
30376	Fee: \$521.25	Benefit: 75% = \$390.95			
		involving division of adhesions in conjunction with another intraa ken to divide the adhesions is between 45 minutes and 2 hours, on es.) (Assist.)			
30378	Fee: \$523.70	Benefit: 75% = \$392.80			
		WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater in the section of long intestinal tube (Anaes.) (Assist.)	ter than 2 hours)		
30379	Fee: \$928.15	Benefit: 75% = \$696.15			
30382		NEOUS FISTULA, radical repair of, involving extensive dissection	n and resection of		

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	bowel (Anaes.) (Assist.)	
	Fee: \$1,306.90 Benefit: 75% = \$980.20	
	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenect node biopsies and oophoropexy (Anaes.) (Assist.)	tomy, liver biopsies, lymph
30384	Fee: \$1,099.40 Benefit: 75% = \$824.55	
	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRI procedure is performed (Anaes.) (Assist.)	HAGE, where no other
30385	Fee: \$563.30 Benefit: 75% = \$422.50	
	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISC not being a service to which another item in this Group applies (Anaes.) (
30387	Fee: \$635.00 Benefit: 75% = \$476.25	
	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist	.)
30388	Fee: \$1,597.55 Benefit: 75% = \$1198.20	
	LAPAROSCOPY, diagnostic, not being a service associated with any oth person 10 years of age or over (Anaes.)	ner laparoscopic procedure, on a
30390	(See para TN.8.15 of explanatory notes to this Category) Fee: \$219.95 Benefit: 75% = \$165.00	
	LAPAROSCOPY with biopsy (Anaes.) (Assist.)	
30391	Fee: \$284.35 Benefit: 75% = \$213.30	
	RADICAL OR DEBULKING OPERATION for advanced intra-abdomin omentectomy, as an independent procedure (Anaes.) (Assist.)	al malignancy, with or without
30392	Fee: \$674.50 Benefit: 75% = \$505.90	
	LAPAROSCOPIC DIVISION OF ADHESIONS in association with anot where the time taken to divide the adhesions exceeds 45 minutes (Anaes.)	1
30393	Fee: \$523.70 Benefit: 75% = \$392.80	
	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendix or for peritonitis from any cause, with or without appendicector	
30394	Fee: \$492.85 Benefit: 75% = \$369.65	
	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of removal of foreign material or enteric contents, with lavage of the entire p abdominal incision, with or without closure of abdomen and with or with (Anaes.) (Assist.)	peritoneal cavity via a major
30396	(See para TN.8.16 of explanatory notes to this Category) Fee: \$1,016.55 Benefit: 75% = \$762.45	
	LAPAROSTOMY, via wound previously made and left open or closed w dressings or packs, and with or without drainage of loculated collections	
30397	Fee: \$232.35 Benefit: 75% = \$174.30	
30399	LAPAROSTOMY, final closure of wound made at previous operation, af	fter removal of dressings or

T8. SUR	GICAL OPERATIO	DNS 1. GENERAL
	packs and removal	of mesh or zipper if previously inserted (Anaes.) (Assist.)
	Fee: \$319.60	Benefit: 75% = \$239.70
		WITH INSERTION OF PORTACATH for administration of cytotoxic therapy nt of reservoir (Anaes.) (Assist.)
30400	Fee: \$632.50	Benefit: 75% = \$474.40
	RETROPERITON	EAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.)
30402	Fee: \$464.60	Benefit: 75% = \$348.45
	VENTRAL, INCIS without mesh (Ana	SIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or nes.) (Assist.)
30403	Fee: \$521.25	Benefit: 75% = \$390.95
		CISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, ransposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.)
30405	Fee: \$914.95	Benefit: 75% = \$686.25
	PARACENTESIS	ABDOMINIS (Anaes.)
30406	Fee: \$52.20	Benefit: 75% = \$39.15 85% = \$44.40
	PERITONEOVEN	OUS shunt, insertion of (Anaes.) (Assist.)
30408	Fee: \$392.10	Benefit: 75% = \$294.10
	LIVER BIOPSY, 1	percutaneous (Anaes.)
30409	Fee: \$174.45	Benefit: 75% = \$130.85 85% = \$148.30
	LIVER BIOPSY b procedure (Anaes.)	y wedge excision when performed in conjunction with another intraabdominal
30411	Fee: \$88.80	Benefit: 75% = \$66.60
	LIVER BIOPSY b (Anaes.)	y core needle, when performed in conjunction with another intra-abdominal procedure
30412	Fee: \$52.35	Benefit: 75% = \$39.30 85% = \$44.50
	LIVER, subsegme	ntal resection of, (local excision), other than for trauma (Anaes.) (Assist.)
30414	Fee: \$689.80	Benefit: 75% = \$517.35
	LIVER, segmental	resection of, other than for trauma (Anaes.) (Assist.)
30415	Fee: \$1,379.50	Benefit: 75% = \$1034.65
		aroscopic marsupialisation of, where the size of the cyst is greater than 5cm in
30416	Fee: \$748.95	Benefit: 75% = \$561.75
		paroscopic marsupialisation of 5 or more, including any cyst greater than 5cm in
30417	Fee: \$1,123.40	Benefit: 75% = \$842.55

T8. SUF	RGICAL OPERATIO	DNS 1. GENERAL			
	LIVER, lobectom	y of, other than for trauma (Anaes.) (Assist.)			
30418	Fee: \$1,597.55	Benefit: 75% = \$1198.20			
	LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a to which item 50950 or 50952 applies (Anaes.) (Assist.)				
30419	Fee: \$817.10	Benefit: 75% = \$612.85 85% = \$735.40			
	LIVER, TRI-SEG (Assist.)	MENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.)			
30421	Fee: \$1,996.55	Benefit: 75% = \$1497.45			
	LIVER, repair of	superficial laceration of, for trauma (Anaes.) (Assist.)			
30422	Fee: \$675.35	Benefit: 75% = \$506.55			
	LIVER, repair of	deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)			
30425	Fee: \$1,306.90	Benefit: 75% = \$980.20			
	LIVER, segmenta	resection of, for trauma (Anaes.) (Assist.)			
30427	Fee: \$1,560.95	Benefit: 75% = \$1170.75			
	LIVER, lobectom	y of, for trauma (Anaes.) (Assist.)			
30428	Fee: \$1,670.00	Benefit: 75% = \$1252.50 85% = \$1588.30			
	LIVER, extended	lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)			
30430	Fee: \$2,323.30	Benefit: 75% = \$1742.50 85% = \$2241.60			
	LIVER ABSCESS	b, open abdominal drainage of (Anaes.) (Assist.)			
30431	Fee: \$521.25	Benefit: 75% = \$390.95 85% = \$443.10			
		(multiple), open abdominal drainage of (Anaes.) (Assist.)			
30433	Fee: \$726.05	Benefit: 75% = \$544.55			
	HYDATID CYST	OF LIVER, peritoneum or viscus, complete removal of contents of, with or without dicles (Anaes.) (Assist.)			
30434	Fee: \$588.15	Benefit: 75% = \$441.15			
		OF LIVER, peritoneum or viscus, complete removal of contents of, with or without dicles, with omentoplasty or myeloplasty (Anaes.) (Assist.)			
30436	Fee: \$653.45	Benefit: 75% = \$490.10			
	HYDATID CYST (Anaes.) (Assist.)	OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall)			
30437	Fee: \$813.30	Benefit: 75% = \$610.00			
	HYDATID CYST	OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)			
30438	Fee: \$1,150.85	Benefit: 75% = \$863.15 85% = \$1069.15			
30439	OPERATIVE CH	OLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA FRASOUND of the biliary tract (including 1 or more examinations performed during			

T8. SUF	GICAL OPERATIO	NS 1. GENERAL	
	the 1 operation) (Anaes.) (Assist.)		
	Fee: \$185.60	Benefit: 75% = \$139.20	
	interventional imag	AM, percutaneous transhepatic, and insertion of biliary drainage tube, using ging techniques - but not including imaging, not being a service associated with a em 30451 applies (Anaes.) (Assist.)	
30440	Fee: \$526.40	Benefit: 75% = \$394.80 85% = \$447.45	
	INTRA OPERATI	VE ULTRASOUND for staging of intra abdominal tumours (Anaes.)	
30441	Fee: \$136.25	Benefit: 75% = \$102.20	
	CHOLEDOCHOS	COPY in conjunction with another procedure (Anaes.)	
30442	Fee: \$185.60	Benefit: 75% = \$139.20	
	CHOLECYSTECT	OMY (Anaes.) (Assist.)	
30443	Fee: \$739.35	Benefit: 75% = \$554.55	
	LAPAROSCOPIC	CHOLECYSTECTOMY (Anaes.) (Assist.)	
30445	Fee: \$739.35	Benefit: 75% = \$554.55	
	LAPAROSCOPIC (Assist.)	CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.)	
30446	Fee: \$739.35	Benefit: 75% = \$554.55	
	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.)		
30448	Fee: \$972.90	Benefit: 75% = \$729.70	
	LAPAROSCOPIC choledochotomy (A	CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic Anaes.) (Assist.)	
30449	Fee: \$1,081.85	Benefit: 75% = \$811.40	
		ILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques e associated with a service to which items 36627, 36630, 36645 or 36648 applies	
30450	Fee: \$524.40	Benefit: 75% = \$393.30 85% = \$445.75	
		AGE TUBE, exchange of, using interventional imaging techniques - but not including a service associated with a service to which item 30440 applies (Anaes.) (Assist.)	
30451	Fee: \$267.65	Benefit: 75% = \$200.75 85% = \$227.55	
	CHOLEDOCHOS (Anaes.) (Assist.)	COPY with balloon dilation of a stricture or passage of stent or extraction of calculi	
30452	Fee: \$377.50	Benefit: 75% = \$283.15	
	CHOLEDOCHOT (Assist.)	OMY (with or without cholecystectomy), with or without removal of calculi (Anaes.)	
30454	Fee: \$862.50	Benefit: 75% = \$646.90	
30455		OMY (with or without cholecystectomy), with removal of calculi including biliary	

T8. SUF	GICAL OPERATION	DNS	1. GENERAL		
	intestinal anastomosis (Anaes.) (Assist.)				
	Fee: \$1,014.05	Benefit: 75% = \$760.55			
	CHOLEDOCHOT (Assist.)	OMY, intrahepatic, involving removal of intrahepatic bile duct calc	uli (Anaes.)		
30457	Fee: \$1,379.50	Benefit: 75% = \$1034.65 85% = \$1297.80			
	calculi, sphinctero	AL OPERATION ON SPHINCTER OF ODDI, involving 1 or more tomy, sphincteroplasty, biopsy, local excision of peri-ampullary or c f the pancreatic duct, pancreatic duct septoplasty, with or without ch	luodenal tumour,		
30458	Fee: \$1,014.05	Benefit: 75% = \$760.55			
		UODENOSTOMY, CHOLECYSTOENTEROSTOMY, EJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior .) (Assist.)	biliary surgery		
30460	Fee: \$862.50	Benefit: 75% = \$646.90			
		CTION of porta hepatis with biliary-enteric anastomoses, not being a service to which item 30443, 30454, 30455, 30458 or 30460 applies			
30461	Fee: \$1,478.40	Benefit: 75% = \$1108.80			
	RADICAL RESE anastomoses (Ana	CTION of common hepatic duct and right and left hepatic ducts, wit es.) (Assist.)	h 2 duct		
30463	Fee: \$1,815.20	Benefit: 75% = \$1361.40			
		CTION of common hepatic duct and right and left hepatic ducts, inv resection of segment or major portion of segment of liver (Anaes.) (A			
30464	Fee: \$2,178.25	Benefit: 75% = \$1633.70			
	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.)				
30466	Fee: \$1,256.05	Benefit: 75% = \$942.05			
	INTRAHEPATIC system (Anaes.) (A	BYPASS of right hepatic ductal system by Roux-en-Y loop to perip Assist.)	bheral ductal		
30467	Fee: \$1,553.70	Benefit: 75% = \$1165.30			
	BILIARY STRIC	TURE, repair of, after 1 or more operations on the biliary tree (Anae	s.) (Assist.)		
30469	Fee: \$1,720.90	Benefit: 75% = \$1290.70 85% = \$1639.20			
	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.)		nt to partial or		
30472	Fee: \$929.35	Benefit: 75% = \$697.05 85% = \$847.65			
	gastroscopy, duod	not being a service to which item 41816 or 41822 applies), enoscopy or panendoscopy (1 or more such procedures), with or wit sociated with a service to which item 30478 or 30479 applies. (Anae			
30473	(See para TN.8.17 o Fee: \$177.10	f explanatory notes to this Category) Benefit: 75% = \$132.85 85% = \$150.55			

T8. SUF	GICAL OPERATIONS	1. GENERAL
	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of intensification where clinically indicated) (Anaes.)	maging
30475	(See para TN.8.17, TN.8.133 of explanatory notes to this Category) Fee: \$348.95 Benefit: 75% = \$261.75 85% = \$296.65	
	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if:	gastroscopy,
	(a) the procedures are performed using one or more of the following endoscopic proc	edures:
	(i) polypectomy;	
	(ii) sclerosing or adrenalin injections;	
	(iii) banding;	
	(iv) endoscopic clips;	
	(v) haemostatic powders;	
	(vi) diathermy;	
	(vii) argon plasma coagulation; and	
	(b) the procedures are for the treatment of one or more of the following:	
	(i) upper gastrointestinal tract bleeding;	
	(ii) polyps;	
	(iii) removal of foreign body;	
	(iv) oesophageal or gastric varices;	
	(v) peptic ulcers;	
	(vi) neoplasia;	
	(vii) benign vascular lesions;	
	(viii) strictures of the gastrointestinal tract;	
	(ix) tumorous overgrowth through or over oesophageal stents;	
	other than a service associated with a service to which item 30473 or 30479 applies (.	Anaes.)
30478	(See para TN.8.17 of explanatory notes to this Category) Fee: \$245.55 Benefit: 75% = \$184.20 85% = \$208.75	
	Endoscopy with laser therapy, for the treatment of one or more of the following:	
30479	(a) neoplasia;	

T8. SUR	GICAL OPERATIONS	1. GENERA	
	(b) benign vascular lesions;		
	(c) strictures of the gastrointestinal tract;		
	(d) tumorous overgrowth through or over oesophageal stents;		
	(e) peptic ulcers;		
	(f) angiodysplasia;		
	(g) gastric antral vascular ectasia;		
	(h) post-polypectomy bleeding;		
	other than a service associated with a service to which item 30473 or 30478 applies (A (See para TN.8.17 of explanatory notes to this Category)	naes.)	
	Fee: \$476.10 Benefit: 75% = \$357.10 85% = \$404.70		
	PERCUTANEOUS GASTROSTOMY (initial procedure):		
	(a) including any associated imaging services; and		
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anae	5.)	
Amend 30481	(See para TN.8.17 of explanatory notes to this Category) Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45		
	PERCUTANEOUS GASTROSTOMY (repeat procedure):		
	(a) including any associated imaging services; and		
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anae	s.)	
Amend 30482	Fee: \$253.85 Benefit: 75% = \$190.40 85% = \$215.80		
	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CI STOMAL INDWELLING DEVICE:	HAIT etc.) or	
	(a) non-endoscopic insertion of; or		
	(b) non-endoscopic replacement of;		
	on a person 10 years of age or over, excluding the insertion of a device for the purpose weight loss (Anaes.)	of facilitating	
Amend 30483	Fee: \$177.05 Benefit: 75% = \$132.80 85% = \$150.50		
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.)		
30484	(See para TN.8.17 of explanatory notes to this Category) Fee: \$364.90 Benefit: 75% = \$273.70 85% = \$310.20		
	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from comm (Anaes.)	non bile duct	
30485	(See para TN.8.17 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$481.60		

T8. SUF	RGICAL OPERATIONS 1. GENE	RAL
	SMALL BOWEL INTUBATION as an independent procedure (Anaes.)	
30488	Fee: \$90.00 Benefit: 75% = \$67.50 85% = \$76.50	
	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.)	
30490	(See para TN.8.17 of explanatory notes to this Category) Fee: \$526.40 Benefit: 75% = \$394.80 85% = \$447.45	
	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.)	
30491	(See para TN.8.17 of explanatory notes to this Category) Fee: \$555.35 Benefit: 75% = \$416.55 85% = \$473.65	
	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.)	
30492	Fee: \$787.30 Benefit: 75% = \$590.50	
	ENDOSCOPIC BILIARY DILATATION (Anaes.)	
30494	(See para TN.8.17 of explanatory notes to this Category) Fee: \$420.50 Benefit: 75% = \$315.40	
	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.)	
30495	Fee: \$787.30 Benefit: 75% = \$590.50	
	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (As	sist.)
30496	Fee: \$588.15 Benefit: 75% = \$441.15 85% = \$506.45	
	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.)	
30497	Fee: \$701.30 Benefit: 75% = \$526.00	
	VAGOTOMY, highly selective (Anaes.) (Assist.)	
30499	Fee: \$834.05 Benefit: 75% = \$625.55	
	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.)	
30500	Fee: \$893.10 Benefit: 75% = \$669.85 85% = \$811.40	
	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.)	
30502	Fee: \$985.70 Benefit: 75% = \$739.30	
	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.)	;
30503	Fee: \$1,103.80 Benefit: 75% = \$827.85 85% = \$1022.10	
	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (An (Assist.)	aes.)
30505	Fee: \$551.85 Benefit: 75% = \$413.90	
	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.)	l
30506	Fee: \$965.75 Benefit: 75% = \$724.35	
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and	1

T8. SUF	GICAL OPERATION	ONS	1. GENERAL
	highly selective va	agotomy (Anaes.) (Assist.)	
	Fee: \$1,016.55	Benefit: 75% = \$762.45	
	BLEEDING PEP' (Anaes.) (Assist.)	TIC ULCER, control of, involving gastric resection (other than wed	ge resection)
30509	Fee: \$1,016.55	Benefit: 75% = \$762.45 85% = \$934.85	
		y (including gastroduodenostomy) or enterocolostomy or enteroente any of items 31569 to 31581 apply (Anaes.) (Assist.)	erostomy, not being
30515	Fee: \$704.35	Benefit: 75% = \$528.30	
	GASTROENTER (Anaes.) (Assist.)	OSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY,	reconstruction of
30517	Fee: \$922.20	Benefit: 75% = \$691.65	
	Partial gastrectom apply (Anaes.) (A	y, not being a service associated with a service to which any of iter ssist.)	ns 31569 to 31581
30518	Fee: \$987.50	Benefit: 75% = \$740.65	
	GASTRIC TUMO (Anaes.) (Assist.)	DUR, removal of, by local excision, not being a service to which ite	m 30518 applies
30520	Fee: \$675.35	Benefit: 75% = \$506.55	
	GASTRECTOMY	Y, TOTAL, for benign disease (Anaes.) (Assist.)	
30521	Fee: \$1,444.90	Benefit: 75% = \$1083.70	
	GASTRECTOMY (Anaes.) (Assist.)	Y, SUBTOTAL RADICAL, for carcinoma, (including splenectomy	when performed)
30523	(See para TN.8.18 c Fee: \$1,510.10	of explanatory notes to this Category) Benefit: 75% = \$1132.60	
		Y, TOTAL RADICAL, for carcinoma (including extended node disend splenectomy when performed) (Anaes.) (Assist.)	section and distal
30524	Fee: \$1,662.65	Benefit: 75% = \$1247.00	
		Y, TOTAL, and including lower oesophagus, performed by left thor of diaphragmatic hiatus, (including splenectomy when performed	
30526	Fee: \$2,156.35	Benefit: 75% = \$1617.30	
		PERATION by fundoplasty, via abdominal or thoracic approach, we obragmatic hiatus not being a service to which item 30601 applies	
30527	(See para TN.8.19 c Fee: \$871.30	of explanatory notes to this Category) Benefit: 75% = \$653.50	
	ANTIREFLUX oj (Anaes.) (Assist.)	peration by fundoplasty, with OESOPHAGOPLASTY for stricture	or short oesophagus
30529	(See para TN.8.19 c Fee: \$1,306.90	of explanatory notes to this Category) Benefit: 75% = \$980.20	
30530	ANTIREFLUX of	peration by cardiopexy, with or without fundoplasty (Anaes.) (Assis	st.)

10. 305	GICAL OPERATIONS	1. GENERAL
	(See para TN.8.19 of explanatory notes to this Category) Fee: \$784.20 Benefit: 75% = \$588.15	
	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or t without closure of the diaphragmatic hiatus, by laparoscopy or open operation	
30532	(See para TN.8.19 of explanatory notes to this Category) Fee: \$900.45 Benefit: 75% = \$675.35	
	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or t FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by lapa (Anaes.) (Assist.)	
30533	(See para TN.8.19 of explanatory notes to this Category) Fee: \$1,071.00 Benefit: 75% = \$803.25	
	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation (Anaes.) (Assist.)	and thoracotomy
30535	Fee: \$1,696.65 Benefit: 75% = \$1272.50	
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilis anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.)	ation, thoracotomy and
30536	Fee: \$1,720.90 Benefit: 75% = \$1290.70	
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilis anastomosis in the neck or chest- conjoint surgery, principal surgeon (including (Assist.)	
30538	Fee: \$1,190.80 Benefit: 75% = \$893.10	
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilis anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.)	ation, thoracotomy and
30539	Fee: \$871.30 Benefit: 75% = \$653.50	
	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdomi anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Ana	
30541	Fee: \$1,517.50 Benefit: 75% = \$1138.15	
	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdomi anastomosis) with posterior or anterior mediastinal placement - conjoint surger (including aftercare) (Anaes.) (Assist.)	
30542	Fee: \$1,031.10 Benefit: 75% = \$773.35	
	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.	
30544	Fee: \$755.20 Benefit: 75% = \$566.40	
	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and tho thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.)	racic mobilisation with
30545	Fee: \$1,837.10 Benefit: 75% = \$1377.85	
	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and tho thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare	

T8. SUF	RGICAL OPERATI	ONS 1. GENERAL
		OMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with osis) - conjoint surgery, co-surgeon (Assist.)
30548	Fee: \$943.80	Benefit: 75% = \$707.85 85% = \$862.10
		OMY with colon or jejunal replacement (abdominal and thoracic mobilisation with dicle in the neck) - 1 surgeon (Anaes.) (Assist.)
30550	Fee: \$2,062.20	Benefit: 75% = \$1546.65
		OMY with colon or jejunal replacement (abdominal and thoracic mobilisation with dicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.)
30551	Fee: \$1,423.15	Benefit: 75% = \$1067.40
		OMY with colon or jejunal replacement (abdominal and thoracic mobilisation with dicle in the neck) - conjoint surgery, co-surgeon (Assist.)
30553	Fee: \$1,052.65	Benefit: 75% = \$789.50 85% = \$970.95
	OESOPHAGECT	OMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.)
30554	Fee: \$2,294.45	Benefit: 75% = \$1720.85
	OESOPHAGECT	OMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon re) (Anaes.) (Assist.)
30556	Fee: \$1,582.80	Benefit: 75% = \$1187.10
	OESOPHAGECT	OMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.)
30557	Fee: \$1,169.00	Benefit: 75% = \$876.75
	OESOPHAGUS,	local excision for tumour of (Anaes.) (Assist.)
30559	Fee: \$849.55	Benefit: 75% = \$637.20 85% = \$767.85
		PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)
30560	Fee. \$9/13 80	Benefit: 75% = \$707.85
30300	Fee: \$943.80 Benefit: 75% = \$707.85 ENTEROSTOMY or COLOSTOMY, closure of (not involving resection of bowel), on a person 10 years of age or over (Anaes.) (Assist.)	
30562	Fee: \$595.00	Benefit: 75% = \$446.25
	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes (Assist.)	
30563	Fee: \$595.00	Benefit: 75% = \$446.25 85% = \$513.30
	SMALL BOWEI	STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.)
30564	Fee: \$772.30	Benefit: 75% = \$579.25
		INE, resection of, without anastomosis (including formation of stoma) (Anaes.)
30565	Fee: \$871.30	Benefit: 75% = \$653.50
20566	SMALL INTEST (Assist.)	INE, resection of, with anastomosis, on a person 10 years of age or over (Anaes.)
30566		

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL		
	Fee: \$967.85	Benefit: 75% = \$725.90		
	INTRAOPERAT (Assist.)	TVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.)		
30568	Fee: \$726.05	Benefit: 75% = \$544.55		
		EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, biopsies (Anaes.) (Assist.)		
30569	Fee: \$370.20	Benefit: 75% = \$277.65		
		APPENDICECTOMY, not being a service to which item 30574 applies on a person 10 years of age or over (Anaes.) (Assist.)		
30571	Fee: \$445.40	Benefit: 75% = \$334.05		
	LAPAROSCOPI	C APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)		
30572	Fee: \$445.40	Benefit: 75% = \$334.05		
	NOTE: Multiple	Operation and Multiple Anaesthetic rules apply to this item		
		OMY, when performed in conjunction with any other intraabdominal procedure incision (Anaes.)		
30574	Fee: \$123.25	Benefit: 75% = \$92.45		
	PANCREATIC A dissection (Anae	ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic s.) (Assist.)		
30575	Fee: \$512.70	Benefit: 75% = \$384.55		
		NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)		
30577	Fee: \$1,089.15	Benefit: 75% = \$816.90		
	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.)			
30578	Fee: \$1,147.20	Benefit: 75% = \$860.40		
	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.)			
30580	Fee: \$1,045.40	Benefit: 75% = \$784.05		
	ENDOCRINE T (Assist.)	UMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.)		
30581	Fee: \$762.35	Benefit: 75% = \$571.80		
	DISTAL PANCE	REATECTOMY (Anaes.) (Assist.)		
30583	Fee: \$1,194.25	Benefit: 75% = \$895.70		
	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.)			
20504	Fee: \$1,762.75	Benefit: 75% = \$1322.10		
30584				

T8. SUF	RGICAL OPERATI	ONS 1. GENERAL		
	means (Anaes.) (Assist.)		
	Fee: \$701.30	Benefit: 75% = \$526.00		
	PANCREATIC C	CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)		
30587	Fee: \$726.05	Benefit: 75% = \$544.55		
	PANCREATICO	-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)		
30589	Fee: \$1,251.10	Benefit: 75% = \$938.35		
	PANCREATICO	-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)		
30590	Fee: \$1,379.50	Benefit: 75% = \$1034.65		
	PANCREATECT (Assist.)	FOMY, near total or total (including duodenum), with or without splenectomy (Anaes.)		
30593	Fee: \$1,887.75	Benefit: 75% = \$1415.85 85% = \$1806.05		
	PANCREATECT resection (Anaes.	FOMY for pancreatitis following previously attempted drainage procedure or partial) (Assist.)		
30594	Fee: \$2,178.25	Benefit: 75% = \$1633.70		
	SPLENORRHAP	PHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)		
30596	Fee: \$897.30	Benefit: 75% = \$673.00		
	SPLENECTOMY (Anaes.) (Assist.)			
30597	Fee: \$720.20	Benefit: 75% = \$540.15		
	SPLENECTOMY incision (Anaes.)	Y, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal (Assist.)		
30599	Fee: \$1,306.90	Benefit: 75% = \$980.20		
	DIAPHRAGMA	TIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)		
30600	Fee: \$777.10	Benefit: 75% = \$582.85		
		ernia, congential repair of, by thoracic or abdominal approach, not being a service to ns 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.)		
30601	Fee: \$957.30	Benefit: 75% = \$718.00		
	PORTAL HYPE	RTENSION, porto-caval shunt for (Anaes.) (Assist.)		
30602	Fee: \$1,553.70	Benefit: 75% = \$1165.30		
	PORTAL HYPE	RTENSION, meso-caval shunt for (Anaes.) (Assist.)		
30603	Fee: \$1,640.90	Benefit: 75% = \$1230.70 85% = \$1559.20		
	PORTAL HYPE	RTENSION, selective spleno-renal shunt for (Anaes.) (Assist.)		
30605	Fee: \$1,865.95	Benefit: 75% = \$1399.50		
	PORTAL HYPE	RTENSION, oesophageal transection via stapler or oversew of gastric varices with or arisation (Anaes.) (Assist.)		
30606	Fee: \$1,110.80	Benefit: 75% = \$833.10		

T8. SUR	GICAL OPERATIONS	1. GENERAL
	SMALL INTESTINE, resection of, with anastomosis, on a person under 10 y (Assist.)	ears of age (Anaes.)
30608	Fee: \$1,258.20 Benefit: 75% = \$943.65	
	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service to which item 30614 applies (Anaes.) (Assist.)	rvice associated with a
30609	Fee: \$464.50 Benefit: 75% = \$348.40	
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, covered by item 31345 and lipomata - removal of by surgical excision, where sent for histological confirmation of diagnosis, on a person under 10 years of which another item in this Group applies (Anaes.) (Assist.)	the specimen excised is
30611	Fee: \$563.35 Benefit: 75% = \$422.55 85% = \$481.65	
	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repaired which item 30403 or 30615 applies, on a person 10 years of age or over (Ana	-
30614	Fee: \$464.50 Benefit: 75% = \$348.40	
	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, reparesection, on a person 10 years of age or over (Anaes.) (Assist.)	ir of, without bowel
30615	Fee: \$521.25 Benefit: 75% = \$390.95	
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels tissue and lymph nodes from one side of the neck, on a person under 10 year	
30618	(See para TN.8.24 of explanatory notes to this Category) Fee: \$522.25 Benefit: 75% = \$391.70 85% = \$443.95	
	LAPAROSCOPIC SPLENECTOMY, on a person under 10 years of age (Ana	aes.) (Assist.)
30619	Fee: \$936.25 Benefit: 75% = \$702.20	
	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring me in a person 10 years of age or over, other than a service to which item 30403 (Assist.)	
30621	Fee: \$407.50 Benefit: 75% = \$305.65	
	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystoste Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pylorop pancreas on a person under 10 years of age (Anaes.) (Assist.)	n, Suture of perforated
30622	(See para TN.8.14 of explanatory notes to this Category) Fee: \$677.65 Benefit: 75% = \$508.25	
	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESION intraabdominal procedure is performed) on a person under 10 years of age (A	
30623	Fee: \$677.65 Benefit: 75% = \$508.25	
	LAPAROTOMY involving division of adhesions in conjunction with another where the time taken to divide the adhesions is between 45 minutes and 2 hou years of age (Anaes.) (Assist.)	
30626	Fee: \$680.80 Benefit: 75% = \$510.60	

T8. SUF	RGICAL OPERATIO	I. GENERA
		diagnostic, not being a service associated with any other laparoscopic procedure, or ears of age (Anaes.)
30627	(See para TN.8.15 of Fee: \$285.95	explanatory notes to this Category) Benefit: 75% = \$214.50
	HYDROCELE, ta	pping of
30628	Fee: \$35.60	Benefit: 75% = \$26.70 85% = \$30.30
	Hydrocele, remova 30644 applies (An	ll of, other than a service associated with a service to which item 30641, 30642 or aes.)
30631	Fee: \$236.65	Benefit: 75% = \$177.50 85% = \$201.20
	-	al correction of, other than a service associated with a service to which item 30641, plies—one procedure (Anaes.) (Assist.)
30635	Fee: \$291.80	Benefit: 75% = \$218.85
		BUTTON, caecostomy antegrade enema device (chait etc) and/or stomal indwelling copic insertion of, or non-endoscopic replacement of, on a person under 10 years of
30636	Fee: \$233.15	Benefit: 75% = \$174.90 85% = \$198.20
	ENTEROSTOMY years of age (Anae	or COLOSTOMY, closure of not involving resection of bowel, on a person under 1 s.) (Assist.)
30637	Fee: \$773.50	Benefit: 75% = \$580.15
	COLOSTOMY O	R ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist
30639	Fee: \$773.50	Benefit: 75% = \$580.15 85% = \$691.80
		l irreducible scrotal hernia, where duration of surgery exceeds 2 hours, in a person 1 r, other than a service to which item 30403, 30405, 30614, 30615 or 30621 applies
30640	Fee: \$914.95	Benefit: 75% = \$686.25
	ORCHIDECTOM (Anaes.) (Assist.)	Y, simple or subscapsular, unilateral with or without insertion of testicular prosthesi
30641	Fee: \$407.50	Benefit: 75% = \$305.65
		ical, unilateral, with or without insertion of testicular prosthesis, other than a service ervice to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist
30642	Fee: \$521.25	Benefit: 75% = \$390.95
		DF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and cision of spermatic cord and testis on a person under 10 years of age (Anaes.) (Assis
30643	Fee: \$677.65	Benefit: 75% = \$508.25
		DF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and cision of spermatic cord and testis on a person 10 years of age or over (Anaes.)
30644	Fee: \$521.25	Benefit: 75% = \$390.95
30645	APPENDICECTO	MY, not being a service to which item 30574 applies, on a person under 10 years of

T8. SUF	GICAL OPERATIONS	1. GENERAL
	age (Anaes.) (Assist.)	
	Fee: \$579.00 Benefit: 75% = \$434.25	
	LAPAROSCOPIC APPENDICECTOMY, on a p	erson under 10 years of age (Anaes.) (Assist.)
30646	Fee: \$579.00 Benefit: 75% = \$434.25	
	HAEMORRHAGE, arrest of, following circumci years of age (Anaes.)	sion requiring general anaesthesia on a person under 10
30649	Fee: \$187.65 Benefit: 75% = \$140.75 859	6 = \$159.55
	Circumcision of the penis (other than a service to	which item 30658 applies)
30654	(See para TN.8.2 of explanatory notes to this Category Fee: \$46.50 Benefit: 75% = \$34.90 85%	
	Circumcision of the penis, when performed in con or Group T10 applies (Anaes.)	njunction with a service to which an item in Group T7
30658	(See para TN.8.2 of explanatory notes to this Category Fee: $$142.00$ Benefit: $75\% = 106.50 859	
	HAEMORRHAGE, arrest of, following circumci of age or over (Anaes.)	sion requiring general anaesthesia on a person 10 years
30663	Fee: \$144.35 Benefit: 75% = \$108.30 859	6 = \$122.70
	PARAPHIMOSIS or PHIMOSIS, reduction of, u incision, not being a service associated with a ser (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 S	INUS OR CYST, excision of (Anaes.)
30676	Fee: \$379.05 Benefit: 75% = \$284.30 85%	6 = \$322.20
	PILONIDAL SINUS, injection of sclerosant fluid	under anaesthesia (Anaes.)
30679	Fee: \$96.30 Benefit: 75% = \$72.25 85%	= \$81.90
	Balloon enteroscopy, examination of the small be	wel (oral approach), with or without biopsy, s of patients with obscure gastrointestinal bleeding, not
	The patient to whom the service is provided must	
	(i) have recurrent or persistent bleeding; and	
	(ii) be anaemic or have active bleeding; and	
30680	(iii) have had an upper gastrointestinal endosco the cause of the bleeding. (Anaes.)	py and a colonoscopy performed which did not identify

T8. SUR	GICAL OPERATIONS	1. GENERAL
	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,170.00 Benefit: 75% = \$877.50 85% = \$1088.30	
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointe in association with another item in this subgroup (with the exception of item 30680 c	stinal bleeding, not
	The patient to whom the service is provided must:	
	(i) have recurrent or persistent bleeding; and	
	(ii) be anaemic or have active bleeding; and	
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed where the cause of the bleeding.	hich did not identify
	(Anaes.)	
30682	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,170.00 Benefit: 75% = \$877.50 85% = \$1088.30	
	Balloon enteroscopy, examination of the small bowel (oral approach), with or withou or more of the following procedures (snare polypectomy, removal of foreign body, d probe, laser coagulation or argon plasma coagulation), for diagnosis and managemen obscure gastrointestinal bleeding, not in association with another item in this subgrou exception of item 30682 or 30686)	iathermy, heater t of patients with
	The patient to whom the service is provided must:	
	(i) have recurrent or persistent bleeding; and	
	(ii) be anaemic or have active bleeding; and	
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed where the cause of the bleeding.	hich did not identify
	(Anaes.)	
30684	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,439.85 Benefit: 75% = \$1079.90 85% = \$1358.15	
	Balloon enteroscopy, examination of the small bowel (anal approach), with or without or more of the following procedures (snare polypectomy, removal of foreign body, d probe, laser coagulation or argon plasma coagulation), for diagnosis and management obscure gastrointestinal bleeding, not in association with another item in this subgrout exception of item 30680 or 30684)	iathermy, heater t of patients with
	The patient to whom the service is provided must:	
30686	(i) have recurrent or persistent bleeding; and	

T8. SUF	RGICAL OPERATIONS 1. GENERA
	(ii) be anaemic or have active bleeding; and
	(iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.)
	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,439.85 Benefit: 75% = \$1079.90 85% = \$1358.15
	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.)
30687	(See para TN.8.17, TN.8.20 of explanatory notes to this Category) Fee: \$476.10 Benefit: 75% = \$357.10 85% = \$404.70
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30688	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$364.90 Benefit: 75% = \$273.70 85% = \$310.20
	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 (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30690	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$481.60
	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 (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30692	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$364.90 Benefit: 75% = \$273.70 85% = \$310.20
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with 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 (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30694	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$481.60
	ENDOSCOPIC ULTRASOUND GUIDED FINE NEEDLE ASPIRATION BIOPSY(S) (endoscopy with ultrasound imaging) to obtain one or more specimens from either:
	(a) mediastinal mass(es) or
	(b) locoregional nodes to stage non-small cell lung carcinoma
30696	not being a service associated with another item in this subgroup or to which items 30710 and 55054

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	apply (Anaes.)
	(See para TN.8.21 of explanatory notes to this Category) Fee: \$563.30 Benefit: 75% = \$422.50 85% = \$481.60
	ENDOBRONCHIAL ULTRASOUND GUIDED BIOPSY(S) (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by either:
	(a) transbronchial biopsy(s) of peripheral lung lesions; or
	(b) fine needle aspiration(s) of a mediastinal mass(es); or
	(c) fine needle aspiration(s) of locoregional nodes to stage non-small cell lung carcinoma
	not being a service associated with another item in this subgroup or to which items 30696, 41892, 41898, and 60500 to 60509 applies (Anaes.)
30710	(See para TN.8.21 of explanatory notes to this Category)Fee: $$563.30$ Benefit: $75\% = 422.50 $85\% = 481.60
	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.)
31000	Fee: \$580.90 Benefit: 75% = \$435.70 85% = \$499.20
	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.)
31001	Fee: \$726.05 Benefit: 75% = \$544.55 85% = \$644.35
	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.)
31002	Fee: \$871.30 Benefit: 75% = \$653.50 85% = \$789.60
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:
	(a) the lesion size is not more than 10 mm in diameter; and
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and
	(c) the specimen excised is sent for histological examination (Anaes.)
31206	Fee: \$95.45 Benefit: 75% = \$71.60 85% = \$81.15
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:
	(a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and
31211	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and

T8. SUF	RGICAL OPERATIONS	. GENERAL
	(c) the specimen excised is sent for histological examination (Anaes.)	
	Fee: \$123.10 Benefit: 75% = \$92.35 85% = \$104.65	
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an or removal of and suture, if:	peration),
	(a) the lesion size is more than 20 mm in diameter; and	
	(b) the removal is from a mucous membrane by surgical excision (other than by shave ex	ccision); and
	(c) the specimen excised is sent for histological examination (Anaes.)	
31216	Fee: \$143.55 Benefit: 75% = \$107.70 85% = \$122.05	
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers (other than scars removed during the surgical approach at an operation), removal of 4 to 10 suture, if:	
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other the excision); and	an by shave
	(c) all of the specimens excised are sent for histological examination (Anaes.)	
31220	Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40	
	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at a removal of 4 to 10 lesions, if:	n operation),
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from a mucous membrane by surgical excision (other than by shave	excision); and
	(c) each site of excision is closed by suture; and	
	(d) all of the specimens excised are sent for histological examination (Anaes.)	
31221	Fee: \$214.55 Benefit: 75% = \$160.95 85% = \$182.40	
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers (other than scars removed during the surgical approach at an operation), removal of more the lesions, if:	
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surg (other than by	rical excision
	shave excision); and	
	(c) each site of excision is closed by suture; and	
	(d) all of the specimens excised are sent for histological examination (Anaes.)	
31225	Fee: \$381.30 Benefit: 75% = \$286.00 85% = \$324.15	
31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPU	JRATIVE

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARB (excision from face or neck) (Anaes.)	AE or NUCHAE
	(See para TN.8.23 of explanatory notes to this Category) Fee: \$369.00 Benefit: 75% = \$276.75 85% = \$313.65	
	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 perce the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	nt of body surface <i>where</i>
31250	Fee: \$369.00 Benefit: 75% = \$276.75 85% = \$313.65	
	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and	if:
	(a) the specimen excised is sent for histological confirmation; and	
	(b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31356, 31 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31375 or 31376 is ex	
31340	Derived Fee: 75% of the fee for excision of malignant tumour	
	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcuta more in diameter, or is sub-fascial, where the specimen is sent for histological co (Anaes.)	
31345	Fee: \$210.95 Benefit: 75% = \$158.25 85% = \$179.35	
	LIPOSUCTION (suction assisted lipolysis) to 1 regional area for treatment of co abdominal or upper arm or thigh fat due to repeated insulin injections, <i>where the</i> <i>and 50mm or more in diameter</i> (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, on a person 10 years of age or over, not being a service which another item in this Group applies (Anaes.) (Assist.)	
31350	Fee: \$433.35 Benefit: 75% = \$325.05 85% = \$368.35	
	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartila by surgical excision, where <i>histological proof of malignancy has been obtained</i> , which another item in this Group applies (Anaes.) (Assist.)	
31355	Fee: \$714.45 Benefit: 75% = \$535.85 85% = \$632.75	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371 31375 or 31376), surgical excision (other than by shave excision) and repair of,	
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, area; and	or from a contiguous
	(b) the necessary excision diameter is less than 6 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31356	(See para TN.8.22, TN.8.125 of explanatory notes to this Category)	

T8. SUR	GICAL OPERATIONS	1. GENERAL	
	Fee: \$221.35 Benefit: 75% = \$166.05 85% = \$188.15		
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic including a cyst, ulcer or scar (other than a scar removed during the surgical approac surgical excision (other than by shave excision) and repair of, if:		
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or f area; and	rom a contiguous	
	(b) the necessary excision diameter is less than 6 mm; and		
	(c) the excised specimen is sent for histological examination;		
	not in association with item 45201 (Anaes.)		
31357	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$109.70 Benefit: 75% = \$82.30 85% = \$93.25		
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	372, 31373, 31374,	
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or f area; and	rom a contiguous	
	(b) the necessary excision diameter is 6 mm or more; and		
	(c) the excised specimen is sent for histological examination; and		
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes	5.)	
31358	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$270.85 Benefit: 75% = \$203.15 85% = \$230.25		
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313 31375 or 31376), surgical excision (other than by shave excision), if:	372, 31373, 31374,	
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the	applicable site); and	
	(b) the necessary excision area is at least one third of the surface area of the applic	able site; and	
	(c) the excised specimen is sent for histological examination; and		
	(d) malignancy is confirmed from the excised specimen or previous biopsy		
	(H) (Anaes.)		
31359	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$330.15 Benefit: 75% = \$247.65		
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic including a cyst, ulcer or scar (other than a scar removed during the surgical approac surgical excision (other than by shave excision) and repair of, if:		
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or f area; and	rom a contiguous	
31360	(b) the necessary excision diameter is 6 mm or more; and		

T8. SUR	GICAL OPERATIONS	1. GENERAL
	(c) the excised specimen is sent for histological examination (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$168.05 Benefit: 75% = \$126.05 85% = \$142.85	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	72, 31373, 31374,
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower including, the	limb (distal to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31361	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$186.70 Benefit: 75% = \$140.05 85% = \$158.70	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic including a cyst, ulcer or scar (other than a scar removed during the surgical approach surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower including, the	limb (distal to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
31362	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$133.90 Benefit: 75% = \$100.45 85% = \$113.85	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	72, 31373, 31374,
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower including, the	limb (distal to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.	.)
31363	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$244.30 Benefit: 75% = \$183.25 85% = \$207.70	

T8. SUF	GICAL OPERATIONS	1. GENERAL
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic including a cyst, ulcer or scar (other than a scar removed during the surgical approach surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower including, the	limb (distal to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31364	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$168.05 Benefit: 75% = \$126.05 85% = \$142.85	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 313 or 31373), surgical excision (other than by shave excision) and repair of, if:	70, 31371, 31372
	(a) the lesion is excised from any part of the body not covered by item 31356, 3135 31363; and	58, 31359, 31361 or
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31365	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$158.30 Benefit: 75% = \$118.75 85% = \$134.60	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic including a cyst, ulcer or scar (other than a scar removed during the surgical approach surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 3136 and	50, 31362 or 31364;
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
31366	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$95.45 Benefit: 75% = \$71.60 85% = \$81.15	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 313 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	72, 31373, 31374,
	(a) the lesion is excised from any part of the body not covered by item 31356, 3135 31363; and	58, 31359, 31361 or
31367	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and	1

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$213.60 Benefit: 75% = \$160.20 85% = \$181.60	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrhei including a cyst, ulcer or scar (other than a scar removed during the surgical approa- surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 312 and	360, 31362 or 31364;
	(b) the necessary excision diameter is at least 15 mm but not more than 30mm; an	nd
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
31368	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$125.55 Benefit: 75% = \$94.20 85% = \$106.75	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	372, 31373, 31374,
	(a) the lesion is excised from any part of the body not covered by item 31356, 313 31363; and	358, 31359, 31361 or
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anae	es.)
31369	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$245.90 Benefit: 75% = \$184.45 85% = \$209.05	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrhei including a cyst, ulcer or scar (other than a scar removed during the surgical approar surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 312 and	360, 31362 or 31364;
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31370	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$143.55 Benefit: 75% = \$107.70 85% = \$122.05	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour carcinoma of skin, definitive surgical excision (other than by shave excision) and re	
31371	(a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, o	r from a contiguous

T8. SUR	GICAL OPERATIONS	1. GENERAL
	area; and	
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$357.00 Benefit: 75% = \$267.75 85% = \$303.45	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of s carcinoma of skin, definitive surgical excision (other than by shave excision) and repair	
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower and including,	limb (distal to,
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31372	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$308.70 Benefit: 75% = \$231.55 85% = \$262.40	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of s carcinoma of skin, definitive surgical excision (other than by shave excision) and repair	
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower and including,	limb (distal to,
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31373	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$356.80 Benefit: 75% = \$267.60 85% = \$303.30	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of s carcinoma of skin, definitive surgical excision (other than by shave excision) and repair	
	(a) the tumour is excised from any part of the body not covered by item 31371, 3137	2 or 31373; and
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination; and	
31374	(d) malignancy is confirmed from the excised specimen or previous biopsy;	

T8. SUR	RGICAL OPERATIONS 1. GENERATIONS	AL
	not in association with item 45201 (Anaes.)	
	(See para TN.8.125, TN.1.21 of explanatory notes to this Category) Fee: \$281.90 Benefit: 75% = \$211.45 85% = \$239.65	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	ell
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and	ł
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31375	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$303.40 Benefit: 75% = \$227.55 85% = \$257.90	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or merkel c carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:	ell
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 31373; and	ł
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31376	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$351.60 Benefit: 75% = \$263.70 85% = \$298.90	
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	r
31400	Fee: \$261.05 Benefit: 75% = \$195.80 85% = \$221.90	
	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.)	n
31403	Fee: \$301.35 Benefit: 75% = \$226.05	
	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.)	
31406	Fee: \$502.15 Benefit: 75% = \$376.65 85% = \$426.85	
	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	
31409	Fee: \$1,560.15 Benefit: 75% = \$1170.15	
	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approac (Anaes.) (Assist.)	ch
31412	Fee: \$1,921.75 Benefit: 75% = \$1441.35	

T8. SUF	RGICAL OPERATIONS 1. GENER	RAL
	LYMPH NODE OF NECK, biopsy of (Anaes.)	
31420	Fee: \$183.90 Benefit: 75% = \$137.95 85% = \$156.35	
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of s tissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anaes.) (Ass	
31423	(See para TN.8.24 of explanatory notes to this Category) Fee: \$401.75 Benefit: 75% = \$301.35 85% = \$341.50	
	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)	
31426	(See para TN.8.24 of explanatory notes to this Category) Fee: \$803.45 Benefit: 75% = \$602.60	
	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessor nerve (Anaes.) (Assist.)	
31429	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,252.10 Benefit: 75% = \$939.10	
	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomoh dissections) (Anaes.) (Assist.)	iyoid
31432	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,339.15 Benefit: 75% = \$1004.40	
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.)	3
31435	(See para TN.8.24 of explanatory notes to this Category) Fee: \$984.30 Benefit: 75% = \$738.25	
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spin accessory nerve (Anaes.) (Assist.)	
31438	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,560.15 Benefit: 75% = \$1170.15	
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taker hour or less (Anaes.) (Assist.)	ı is 1
31450	Fee: \$406.65 Benefit: 75% = \$305.00	
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taker more than 1 hour (Anaes.) (Assist.)	ı in
31452	Fee: \$711.50 Benefit: 75% = \$533.65	
	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.)
31454	Fee: \$563.30 Benefit: 75% = \$422.50	
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of t feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.)	he
31456	Fee: \$245.55 Benefit: 75% = \$184.20	
31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of t feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of	

T8. SUF	GICAL OPERATIO	DNS	1. GENERAL
	imaging intensific	ation is clinically indicated (Anaes.)	
	Fee: \$294.65	Benefit: 75% = \$221.00	
	PERCUTANEOU services (Anaes.)	S GASTROSTOMY TUBE, jejunal extension to, including any a (Assist.)	ssociated imaging
31460	Fee: \$357.00	Benefit: 75% = \$267.75	
	OPERATIVE FEB resection (Anaes.)	EDING JEJUNOSTOMY performed in conjunction with major up (Assist.)	oper gastro-intestinal
31462	Fee: \$521.25	Benefit: 75% = \$390.95	
	without closure of	PERATION BY FUNDOPLASTY, via abdominal or thoracic app the diaphragmatic hiatus, by laparoscopic technique - not being a s (Anaes.) (Assist.)	
31464	(See para TN.8.19 o Fee: \$871.30	f explanatory notes to this Category) Benefit: 75% = \$653.50	
		PERATION BY FUNDOPLASTY, via abdominal or thoracic app the diaphragmatic hiatus, revision procedure, by laparoscopy or o	
31466	(See para TN.8.19 o Fee: \$1,306.95	f explanatory notes to this Category) Benefit: 75% = \$980.25	
		AGEAL HIATUS HERNIA, repair of, with complete reduction of iatus, with or without fundoplication (Anaes.) (Assist.)	hernia, resection of
31468	Fee: \$1,435.85	Benefit: 75% = \$1076.90	
	LAPAROSCOPIC	C SPLENECTOMY, on a person 10 years of age or over (Anaes.)	(Assist.)
31470	Fee: \$720.20	Benefit: 75% = \$540.15	
	CHOLEDOCHOJ	UODENOSTOMY, CHOLECYSTOENTEROSTOMY, EJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where ped (Anaes.) (Assist.)	prior biliary surgery
31472	Fee: \$1,169.80	Benefit: 75% = \$877.35	
		IN LESION up to and including 50mm in diameter, including sim ibrocystic disease, open surgical biopsy or excision of, with or wi	
31500	(See para TN.8.25 o Fee: \$260.05	f explanatory notes to this Category) Benefit: $75\% = 195.05 $85\% = 221.05	
	BREAST, BENIG	N LESION more than 50mm in diameter, excision of (Anaes.) (A	Assist.)
31503	(See para TN.8.25 o Fee: \$346.75	f explanatory notes to this Category) Benefit: $75\% = 260.10 $85\% = 294.75	
		RMALITY detected by mammography or ultrasound where guide dure is performed, excision biopsy of (Anaes.) (Assist.)	ewire or other
31506	(See para TN.8.25 o Fee: \$390.10	f explanatory notes to this Category) Benefit: 75% = \$292.60	
31509	BREAST, MALIC	GNANT TUMOUR, open surgical biopsy of, with or without frozen	en section histology

T8. SUF	RGICAL OPERATIONS 1. GENERA
	(Anaes.)
	(See para TN.8.25 of explanatory notes to this Category) Fee: 346.75 Benefit: $75\% = 260.10$ $85\% = 294.75$
	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.)
21510	
31512	Fee: \$650.15 Benefit: 75% = \$487.65 BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant
	tumour (Anaes.) (Assist.)
31515	(See para TN.8.25 of explanatory notes to this Category) Fee: \$436.15 Benefit: 75% = \$327.15
	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology when targeted intraoperative radiotherapy (using an Intrabeam® device) is performed concurrently, if the requirements of item 15900 are met for the patient (Anaes.) (Assist.)
31516	Fee: \$867.00 Benefit: 75% = \$650.25
	BREAST, total mastectomy (H) (Anaes.) (Assist.)
31519	Fee: \$736.05 Benefit: 75% = \$552.05
	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.)
31524	Fee: \$1,040.25 Benefit: 75% = \$780.20
	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)
31525	Fee: \$520.00 Benefit: 75% = \$390.00
	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:
	(a) microcalcification of lesion; or
	(b) impalpable lesion less than 1cm in diameter
	- including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply
31530	Fee: \$595.65 Benefit: 75% = \$446.75 85% = \$513.95
	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound imaging guided - but not including imaging (Anaes.)
31533	(See para TN.8.26 of explanatory notes to this Category)Fee: \$137.90Benefit: $75\% = 103.45 $85\% = 117.25
	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.)
31536	Fee: \$189.40 Benefit: 75% = \$142.05 85% = \$161.00
31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian Colleg of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter,

T8. SUF	RGICAL OPERAT	IONS 1. GENE	RAL
	not being a serv	ce to which item 31530, 31536 or 31548 applies (Anaes.)	
	(See para TN.8.2, Fee: \$398.80	TN.8.27 of explanatory notes to this Category) Benefit: 75% = \$299.10	
	radiologist as de interventional in	guidewire localisation of lesion, by hookwire or similar device, when conducted b termined by the Royal Australian and New Zealand College of Radiologists, using haging techniques prior to using a bore-enbloc stereotactic biopsy - including imagi ce associated with a service to which item 31536 applies (Anaes.)	•
31542	(See para TN.8.2, Fee: \$196.95	TN.8.28 of explanatory notes to this Category) Benefit: 75% = \$147.75 85% = \$167.45	
	histological examples of Surgeons; when including initial imaging techniq	SY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biops nination, when conducted by a surgeon as determined by the Royal Australasian Co ere imaging has demonstrated an impalpable lesion of less than 15mm in diameter, guidewire localisation of lesion, by hookwire or similar device, using interventiona ues and including imaging not being a service associated with a service to which ite 31548 applies (Anaes.)	ollege
		TN.8.27 of explanatory notes to this Category)	
31545		Benefit:75% = \$446.7585% = \$513.95SY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for nination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.)	
31548	Fee: \$137.90	Benefit: 75% = \$103.45 85% = \$117.25	
	granulomatous r	MATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, nastitis or similar, exploration and drainage of when undertaken in the operating the cluding aftercare (Anaes.)	eatre
31551	Fee: \$216.75	Benefit: 75% = \$162.60	
	BREAST, micro	dochotomy of, for benign or malignant condition (Anaes.) (Assist.)	
31554	Fee: \$433.50	Benefit: 75% = \$325.15	
	BREAST CENT	RAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)	
31557	Fee: \$346.75	Benefit: 75% = \$260.10 85% = \$294.75	
		BREAST TISSUE, excision of (Anaes.) (Assist.)	
31560	Fee: \$346.75 Extended Medi	Benefit: 75% = \$260.10 85% = \$294.75 care Safety Net Cap: \$277.40	
	INVERTED NI	PPLE, surgical eversion of (Anaes.)	
31563	Fee: \$259.75	Benefit: 75% = \$194.85 85% = \$220.80	
	ACCESSORY	IIPPLE, excision of (Anaes.)	
31566	Fee: \$129.95	Benefit: 75% = \$97.50 85% = \$110.50	
		BARIATRIC	
		ic band, placement of, with or without crural repair taking 45 minutes or less, for a ically severe obesity (Anaes.) (Assist.)	
31569	(See para TN.8.29 Fee: \$849.55	of explanatory notes to this Category) Benefit: 75% = \$637.20	

T8. SUF	RGICAL OPERAT	IONS	1. GENERAL
	minutes or less, f	y Roux-en-Y including associated anastomoses, with or w for a patient with clinically severe obesity not being assoc ies (Anaes.) (Assist.)	
31572	(See para TN.8.29 Fee: \$1,045.40	of explanatory notes to this Category) Benefit: 75% = \$784.05	
	Sleeve gastrector severe obesity (A	my, with or without crural repair taking 45 minutes or less Anaes.) (Assist.)	, for a patient with clinically
31575	(See para TN.8.29 Fee: \$849.55	of explanatory notes to this Category) Benefit: 75% = \$637.20	
		cluding by gastric plication), with or without crural repair nically severe obesity (Anaes.) (Assist.)	taking 45 minutes or less, for
31578	(See para TN.8.29 Fee: \$849.55	of explanatory notes to this Category) Benefit: 75% = \$637.20	
		y biliopancreatic diversion with or without duodenal swite , with or without crural repair taking 45 minutes or less, f Anaes.) (Assist.)	
31581	(See para TN.8.29 Fee: \$1,045.40	of explanatory notes to this Category) Benefit: 75% = \$784.05	
	gastroplasty (exc	of adjustable gastric banding (removal or replacement of cluding by gastric plication) or biliopancreatic diversion be apply (Anaes.) (Assist.)	
31584	(See para TN.8.30 Fee: \$1,539.10	of explanatory notes to this Category) Benefit: 75% = \$1154.35	
	Adjustment of ga	astric band as an independent procedure including any ass	ociated consultation
31587	Fee: \$97.95	Benefit: 75% = \$73.50 85% = \$83.30	
	Adjustment of ga	astric band reservoir, repair, revision or replacement of (A	naes.) (Assist.)
31590	Fee: \$251.70	Benefit: 75% = \$188.80 85% = \$213.95	
	Surgical reversal items 31569 to 3	of an existing bariatric procedure performed in association 1581 apply.	on with a service to which
	(Anaes.) (Assis	t.)	
31591	(See para TN.8.30 Fee: \$1,539.10	of explanatory notes to this Category) Benefit: 75% = \$1154.35	
T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL
	Group T8. Surgical Operations		
		Subgroup 2. Colorectal	
		FINE, resection of, without anastomosis, including right h ma) (Anaes.) (Assist.)	emicolectomy (including

T8. SUF		NS 2. COLORECTA	
	LARGE INTESTI	NE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)	
32003	Fee: \$1,078.80	Benefit: 75% = \$809.10	
		NE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) is, not being a service associated with a service to which item 32000, 32003, 32005 o nes.) (Assist.)	
32004	Fee: \$1,150.35	Benefit: 75% = \$862.80	
		NE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) not being a service associated with a service to which item 32000, 32003, 32004 or nes.) (Assist.)	
32005	Fee: \$1,299.55	Benefit: 75% = \$974.70	
	LEFT HEMICOLE stoma) (Anaes.) (A	CTOMY, including the descending and sigmoid colon (including formation of ssist.)	
32006	Fee: \$1,150.35	Benefit: 75% = \$862.80	
	TOTAL COLECT	OMY AND ILEOSTOMY (Anaes.) (Assist.)	
32009	Fee: \$1,364.60	Benefit: 75% = \$1023.45	
	TOTAL COLECT	OMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.)	
32012	Fee: \$1,507.40	Benefit: 75% = \$1130.55	
	TOTAL COLECT (Assist.)	OMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.)	
32015	Fee: \$1,852.50	Benefit: 75% = \$1389.40	
		OMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.)	
32018	Fee: \$1,570.85	Benefit: 75% = \$1178.15	
		OMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED OPERATION; PERINEAL RESECTION (Assist.)	
32021	Fee: \$563.30	Benefit: 75% = \$422.50	
	-	on of stent or stents for large bowel obstruction, stricture or stenosis, including by image intensification, where the obstruction is due to:	
	a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or		
	b) an unkno	wn diagnosis (Anaes.)	
32023	(See para TN.8.17 of Fee: \$555.35	explanatory notes to this Category) Benefit: 75% = \$416.55	
	ANASTOMOSIS	RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL of the rectum) greater than 10 centimetres from the anal verge excluding resection o e not being a service associated with a service to which item 32103, 32104 or 32106 assist.)	
32024	Fee: \$1,364.60	Benefit: 75% = \$1023.45	
32025	RECTUM, LOW H	ESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL	

T8. SUF	GICAL OPERATI	ONS	2. COLORECTAL
		(of the rectum) less than 10 centimetres service associated with a service to whice	from the anal verge, with or without covering ch item 32103, 32104 or 32106 applies
	Fee: \$1,825.30	Benefit: 75% = \$1369.00	
			, with or without covering stoma, where the less from the anal verge (Anaes.) (Assist.)
32026	Fee: \$1,965.65	Benefit: 75% = \$1474.25	
		OR ULTRA LOW RESTORATIVE RE or without covering stoma (Anaes.) (As	SECTION, with peranal sutured coloanal sist.)
32028	Fee: \$2,106.20	Benefit: 75% = \$1579.65	
		RVOIR, construction of, being a service oup applies (Anaes.) (Assist.)	associated with a service to which any other
32029	Fee: \$421.20	Benefit: 75% = \$315.90	
	RECTOSIGMOII	DECTOMY (Hartmann's operation) (An	aes.) (Assist.)
32030	Fee: \$1,031.35	Benefit: 75% = \$773.55	
	RESTORATION stoma (Anaes.) (A	6	milar operation, including dismantling of the
32033	Fee: \$1,507.40	Benefit: 75% = \$1130.55	
	SACROCOCCY	GEAL AND PRESACRAL TUMOUR e	excision of (Anaes.) (Assist.)
32036	Fee: \$1,911.80	Benefit: 75% = \$1433.85	
	RECTUM AND	ANUS, ABDOMINOPERINEAL RESEC	CTION OF 1 surgeon (Anaes.) (Assist.)
32039	Fee: \$1,535.05	Benefit: 75% = \$1151.30	
		ANUS, ABDOMINOPERINEAL RESECt dominal resection (Anaes.) (Assist.)	CTION OF, COMBINED SYNCHRONOUS
32042	Fee: \$1,293.15	Benefit: 75% = \$969.90	
		ANUS, ABDOMINOPERINEAL RESEC	CTION OF, COMBINED SYNCHRONOUS
32045	Fee: \$483.95	Benefit: 75% = \$363.00	
		NUS, abdomino-perineal resection of, com ne perineal surgeon also provides assistan	mbined synchronous operation - perineal nee to the abdominal surgeon (Assist.)
32046	Fee: \$747.90	Benefit: 75% = \$560.95	
	PERINEAL PRO	CTECTOMY (Anaes.) (Assist.)	
32047	Fee: \$871.30	Benefit: 75% = \$653.50	
		FOMY with excision of rectum and ileoa without creation of temporary ileostomy	
32051	Fee: \$2,316.60	Benefit: 75% = \$1737.45	
32054	TOTAL COLEC	FOMY with excision of rectum and ileoa without creation of temporary ileostomy	

T8. SUF	GICAL OPERATIONS 2. COLORECTAL
	(including aftercare) (Anaes.) (Assist.)
	Fee: \$2,126.20 Benefit: 75% = \$1594.65
	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.)
32057	Fee: \$563.30 Benefit: 75% = \$422.50
	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.)
32060	Fee: \$2,316.60 Benefit: 75% = \$1737.45
	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.)
32063	Fee: \$2,126.20 Benefit: 75% = \$1594.65
	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.)
32066	Fee: \$563.30 Benefit: 75% = \$422.50
	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.)
32069	Fee: \$1,713.65 Benefit: 75% = \$1285.25
	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy
32072	Fee: \$47.85 Benefit: 75% = \$35.90 85% = \$40.70
	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.)
32075	Fee: \$75.05 Benefit: 75% = \$56.30 85% = \$63.80
	Flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy up to the hepatic flexure, with or without biopsy, other than a service associated with a service to which item 32090 or 32093 applies.
	(Anaes.)
32084	(See para TN.8.17, TN.8.134 of explanatory notes to this Category) Fee: \$111.35 Benefit: 75% = \$83.55 85% = \$94.65
	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, one or more of, other than a service associated with a service to which item 32090 or 32093 applies
	(Anaes.)
32087	(See para TN.8.17, TN.8.134 of explanatory notes to this Category)

T8. SUF	GICAL OPERATIONS	2. COLORECTAL
	Fee: \$204.70 Benefit: 75% = \$153.55 85% = \$1	74.00
	FIBREOPTIC COLONOSCOPY examination of the co WITHOUT BIOPSY, following a positive faecal occul National Bowel Cancer Screening Program. (Anaes.)	
32088	(See para TN.8.17 of explanatory notes to this Category) Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$2	84.20
	Endoscopic examination of the colon beyond the hepati the REMOVAL OF 1 OR MORE POLYPS, following registered on the National Bowel Cancer Screening Pro	a positive faecal occult blood test for a participant
32089	(See para TN.8.17 of explanatory notes to this Category) Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$3	98.85
	FIBREOPTIC COLONOSCOPY examination of color WITHOUT BIOPSY (Anaes.)	a beyond the hepatic flexure WITH or
32090	(See para TN.8.17, TN.8.134 of explanatory notes to this Cate Fee: \$334.35 Benefit: 75% = \$250.80 85% = \$2	
	Endoscopic examination of the colon beyond the hepati the REMOVAL OF 1 OR MORE POLYPS, or the treat post-polypectomy bleeding by ARGON PLASMA CO.	tment of radiation proctitis, angiodysplasia or
32093	(See para TN.8.17, TN.8.134 of explanatory notes to this Cate Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$3	
	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes	
32094	(See para TN.8.17 of explanatory notes to this Category) Fee: \$551.85 Benefit: 75% = \$413.90	
	ENDOSCOPIC EXAMINATION of SMALL BOWEL or without biopsies (Anaes.)	with flexible endoscope passed by stoma, with
32095	(See para TN.8.17 of explanatory notes to this Category) Fee: \$127.80 Benefit: 75% = \$95.85 85% = \$10	8.65
	RECTAL BIOPSY, full thickness, under general anaest nerve block where undertaken in a hospital (Anaes.) (A	
32096	Fee: \$256.95 Benefit: 75% = \$192.75	
	RECTAL TUMOUR of 5 centimetres or less in diameter (Assist.)	er, per anal submucosal excision of (Anaes.)
32099	Fee: \$333.20 Benefit: 75% = \$249.90	
	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination per anal submucosal excision of (Anaes.) (Assist.)	
32102	Fee: \$634.70 Benefit: 75% = \$476.05	
	RECTAL TUMOUR, of less than 4 cm in diameter, per either 3 dimensional or 2 dimensional optic viewing sys during colonoscopy or by local excision, other than a se 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist	stems, if removal is unable to be performed ervice associated with a service to which item
32103		

T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL
	(See para TN.8.31 Fee: \$772.30	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$579.25	
	RECTAL TUMO incorporating eit performed during	DUR, of 4 cm or greater in diameter, per anal excision of, u her 3 dimensional or 2 dimensional optic viewing systems, g colonoscopy or by local excision, other than a service ass 4, 32025, 32103 or 32106 applies (Anaes.) (Assist.)	if removal is unable to be
32104	(See para TN.8.31 Fee: \$999.65	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$749.75	
	ANORECTAL O	CARCINOMA per anal full thickness excision of (Anaes.)	(Assist.)
32105	Fee: \$483.95	Benefit: 75% = \$363.00 85% = \$411.40	
	rectoscopy incor unable to be perf cavity, other than applies (Anaes.)	RAL INTRAPERITONEAL RECTAL TUMOUR, per ana porating either 3 dimensional or 2 dimensional optic viewin ormed during colonoscopy and if removal requires dissection a service associated with a service to which item 32024, 3 (Assist.) , TN.8.17 of explanatory notes to this Category)	ng systems, if removal is on within the peritoneal
32106	Fee: \$1,364.60	Benefit: 75% = \$1023.45 85% = \$1282.90	
	RECTAL TUMO	OUR, transsphincteric excision of (Kraske or similar operat	ion) (Anaes.) (Assist.)
32108	Fee: \$999.65	Benefit: 75% = \$749.75	
	RECTAL PROL	APSE Delorme procedure for (Anaes.) (Assist.)	
32111	Fee: \$634.70	Benefit: 75% = \$476.05	
	RECTAL PROL	APSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.)	
32112	Fee: \$772.30	Benefit: 75% = \$579.25	
	RECTAL STRIC	STRICTURE, per anal release of (Anaes.)	
32114	Fee: \$174.45	Benefit: 75% = \$130.85 85% = \$148.30	
	RECTAL STRICTURE, dilatation of (Anaes.)		
32115	Fee: \$126.85	Benefit: 75% = \$95.15	
		APSE, abdominal rectopexy of (Anaes.) (Assist.)	
32117	Fee: \$999.65	Benefit: 75% = \$749.75	
02117		APSE, perineal repair of (Anaes.) (Assist.)	
32120	Fee: \$256.95	Benefit: 75% = \$192.75	
22120		JRE, anoplasty for (Anaes.) (Assist.)	
32123	Fee: \$333.20	Benefit: 75% = \$249.90 85% = \$283.25	
52125		INENCE, Parks' intersphincteric procedure for (Anaes.) (A	Assist.)
22126			,
32126	Fee: \$483.95	Benefit: 75% = \$363.00 TER, direct repair of (Anaes.) (Assist.)	
aa		- · · · · · · ·	
32129	Fee: \$634.70	Benefit: 75% = \$476.05	

T8. SUF		IONS 2. COLORECTAL	
	RECTOCELE, tr	ransanal repair of rectocele (Anaes.) (Assist.)	
32131	Fee: \$533.60	Benefit: 75% = \$400.20	
	HAEMORRHOI	DS OR RECTAL PROLAPSE sclerotherapy for (Anaes.)	
32132	Fee: \$45.10	Benefit: 75% = \$33.85 85% = \$38.35	
		DS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, fra red therapy for (Anaes.)	
32135	Fee: \$67.50	Benefit: 75% = \$50.65 85% = \$57.40	
	HAEMORRHOI	DECTOMY including excision of anal skin tags when performed (Anaes.)	
32138	Fee: \$367.75	Benefit: 75% = \$275.85 85% = \$312.60	
		DECTOMY involving third or fourth degree haemorrhoids, including excision of anal erformed (Anaes.) (Assist.)	
32139	Fee: \$367.75	Benefit: 75% = \$275.85	
	ANAL SKIN TA	GS or ANAL POLYPS, excision of 1 or more of (Anaes.)	
32142	Fee: \$67.50	Benefit: 75% = \$50.65 85% = \$57.40	
	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.)		
32145	Fee: \$135.05	Benefit: 75% = \$101.30	
	PERIANAL THE	ROMBOSIS, incision of (Anaes.)	
32147	Fee: \$45.10	Benefit: 75% = \$33.85 85% = \$38.35	
	OPERATION FO only (Anaes.) (A	DR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation ssist.)	
32150	Fee: \$256.95	Benefit: 75% = \$192.75 85% = \$218.45	
	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.)		
32153	Fee: \$70.10	Benefit: 75% = \$52.60	
	FISTULA-IN-AN	NO, SUBCUTANEOUS, excision of (Anaes.)	
32156	Fee: \$131.75	Benefit: 75% = \$98.85 85% = \$112.00	
		A, treatment of, by excision or by insertion of a Seton, or by a combination of both lving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)	
32159	Fee: \$333.20	Benefit: 75% = \$249.90	
		A, treatment of, by excision or by insertion of a Seton, or by a combination of both living the upper half of the anal sphincter mechanism (Anaes.) (Assist.)	
32162	Fee: \$483.95	Benefit: 75% = \$363.00	
	ANAL FISTULA	A, repair of, by mucosal flap advancement (Anaes.) (Assist.)	
32165	Fee: \$634.70	Benefit: 75% = \$476.05 85% = \$553.00	

T8. SUR	GICAL OPERATI	ONS 2. COLORECTAL
	ANAL FISTULA	- readjustment of Seton (Anaes.)
32166	Fee: \$206.20	Benefit: 75% = \$154.65 85% = \$175.30
	FISTULA WOUI (Anaes.)	D, review of, under general or regional anaesthetic, as an independent procedure
32168	Fee: \$131.75	Benefit: 75% = \$98.85
		XAMINATION, with or without biopsy, under general anaesthetic, not being a service service to which another item in this Group applies (Anaes.)
32171	Fee: \$88.80	Benefit: 75% = \$66.60
	INTR-AANAL, p	erianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)
32174	Fee: \$88.80	Benefit: 75% = \$66.60 85% = \$75.50
		ERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating al (excluding aftercare) (Anaes.)
32175	Fee: \$162.65	Benefit: 75% = \$122.00
	(excluding puden	removal of, under general anaesthesia, or under regional or field nerve block dal block) requiring admission to a hospital, where the time taken is less than or equal t being a service associated with a service to which item 35507 or 35508 applies
32177	Fee: \$174.25	Benefit: 75% = \$130.70
	(excluding puden	removal of, under general anaesthesia, or under regional or field nerve block dal block) requiring admission to a hospital, where the time taken is greater than 45 g a service associated with a service to which item 35507 or 35508 applies (Anaes.)
32180	Fee: \$256.95	Benefit: 75% = \$192.75
	INTESTINAL SI	ING PROCEDURE prior to radiotherapy (Anaes.) (Assist.)
32183	Fee: \$561.65	Benefit: 75% = \$421.25
	COLONIC LAV	AGE, total, intra operative (Anaes.) (Assist.)
32186	Fee: \$561.65	Benefit: 75% = \$421.25
	DISTAL MUSCI	E, devascularisation of (Anaes.) (Assist.)
32200	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35
	ANAL OR PERI	VEAL GRACILOPLASTY (Anaes.) (Assist.)
32203	Fee: \$635.00	Benefit: 75% = \$476.25
	STIMULATOR A	ND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.)
32206	Fee: \$573.70	Benefit: 75% = \$430.30
	ANAL OR PERI (Assist.)	NEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.)
32209	Fee: \$921.95	Benefit: 75% = \$691.50
	GRACILIS NEO	SPHINCTER PACEMAKER, replacement of (Anaes.)
32210	Fee: \$255.45	Benefit: 75% = \$191.60 85% = \$217.15

T8. SUF	RGICAL OPERATIONS	2. COLORECTAL
	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation performed in the operating theatre of a hospital, excluding aftercare (Anaes.)	n proctitis, where
32212	Fee: \$136.25 Benefit: 75% = \$102.20	
	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance intraoperative test stimulation, to manage faecal incontinence in a patient who	
	a) has an anatomically intact but functionally deficient anal sphincter; and	
	b) has faecal incontinence that has been refractory to conservative non-surgica months;	l treatment for at least 12
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months (Anaes.)	
32213	Fee: \$660.95 Benefit: 75% = \$495.75	
	Neurostimulator or receiver, subcutaneous placement of, involving placement extension wire to a sacral nerve electrode using fluoroscopic guidance, to man a patient who:	
	a) has an anatomically intact but functionally deficient anal sphincter; and	
	b) has faecal incontinence that has been refractory to conservative non-surgica months;	l treatment for at least 12
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
32214		

T8. SUF	GICAL OPERATIONS 2. COLORECTA
	i) has functional effects of previous pelvic irradiation; or
1	j) has congenital or acquired malformations of the sacrum; or
1	k) has had rectal or anal surgery within the previous 12 months
1	(Anaes.) (Assist.)
	Fee: \$334.00 Benefit: 75% = \$250.50
	Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who:
1	a) is medically unfit for surgery; or
1	b) is pregnant or planning pregnancy; or
1	c) has irritable bowel syndrome; or
1	d) has congenital anorectal malformations; or
1	e) has active anal abscesses or fistulas; or
1	f) has anorectal organic bowel disease, including cancer; or
1	g) has functional effects of previous pelvic irradiation; or
1	h) has congenital or acquired malformations of the sacrum; or
1	i) has had rectal or anal surgery within the previous 12 months
1	–each day
32215	Fee: \$125.40 Benefit: 75% = \$94.05 85% = \$106.60
	Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who:
1	a) has an anatomically intact but functionally deficient anal sphincter; and
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;
1	other than a patient who:
1	c) is medically unfit for surgery; or
1	d) is pregnant or planning pregnancy; or
l	e) has irritable bowel syndrome; or
l	f) has congenital anorectal malformations; or
l	g) has active anal abscesses or fistulas; or
	h) has anorectal organic bowel disease, including cancer; or
32216	

T8. SUF	RGICAL OPERATIONS 2. COLORECTAI
	i) has functional effects of previous pelvic irradiation; or
	j) has congenital or acquired malformations of the sacrum; or
	k) has had rectal or anal surgery within the previous 12 months
	other than a service to which item 32213 applies
	(Anaes.)
	Fee: \$593.55 Benefit: 75% = \$445.20
	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted to manage faeca incontinence in a patient who:
	a) has an anatomically intact but functionally deficient anal sphincter; and
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;
	other than a patient who:
	c) is medically unfit for surgery; or
	d) is pregnant or planning pregnancy; or
	e) has irritable bowel syndrome; or
	f) has congenital anorectal malformations; or
	g) has active anal abscesses or fistulas; or
	h) has anorectal organic bowel disease, including cancer; or
	i) has functional effects of previous pelvic irradiation; or
	j) has congenital or acquired malformations of the sacrum; or
	k) has had rectal or anal surgery within the previous 12 months
	(Anaes.)
32217	Fee: \$156.30 Benefit: 75% = \$117.25
	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patien who:
	a) has an anatomically intact but functionally deficient anal sphincter; and
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;
	other than a patient who:
	c) is medically unfit for surgery; or
32218	d) is pregnant or planning pregnancy; or

T8. SUF	URGICAL OPERATIONS 2.	COLORECTAL
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	(Anaes.)	
	Fee: \$156.30 Benefit: 75% = \$117.25	
	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of whom conservative and other less invasive forms of treatment are contraindicated or hav failed. Contraindicated in:	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive de diseases or a scarred or fragile perineum; and	egenerative
	(b) patients who have had an adverse reaction or radiopaque solution; and	
	(c) patients who enage in receptive anal intercourse (Anaes.) (Assist.)	
32220	Fee: \$903.90 Benefit: 75% = \$677.95 85% = \$822.20	
	Removal or revision of an artificial bowel sphincter (with or without replacement) for se incontinence in the treatment of a patient for whom conservative and other less invasive treatment are contraindicated or have failed. Contraindicated in:	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive de diseases or a scarred or fragile perineum; and	egenerative
	(b) patients who have had an adverse reaction to radiopaque solution; and	
	(c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)	
32221	Fee: \$903.90 Benefit: 75% = \$677.95 85% = \$822.20	
T8. SUF	URGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations	
	Subgroup 3. Vascular	
	VARICOSE VEINS	
	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple is sclerosant using continuous compression techniques, including associated consultation - not being a service associated with any other varicose vein operation on the same leg (ex- care) - to a maximum of 6 treatments in a 12 month period (Anaes.)	1 or both legs -
32500	(See para TN.8.4, TN.8.32 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35 Extended Medicare Safety Net Cap: \$120.80	
	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, n sclerosant using continuous compression techniques, including associated consunot being a service associated with any other varicose vein operation on the same care) where it can be demonstrated that truncal reflux in the long or short sapher excluded by duplex examination - and that a 7th or subsequent treatment (inclus which item 32500 applies) is indicated in a 12 month period	Iltation - 1 or both legs - ne leg, (excluding after- nous veins has been
32501	(See para TN.8.32 of explanatory notes to this Category) Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35 Extended Medicare Safety Net Cap: \$87.85	
	VARICOSE VEINS, multiple excision of tributaries, with or without division or veins - 1 leg - not being a service associated with a service to which item 32507 32517 applies on the same leg (Anaes.)	
32504	(See para TN.8.32 of explanatory notes to this Category) Fee: \$267.65 Benefit: 75% = \$200.75 85% = \$227.55 Extended Medicare Safety Net Cap: \$214.15	
	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompeter leg - not being a service associated with a service to which item 32508, 32511, 3 on the same leg (Anaes.) (Assist.)	
32507	(See para TN.8.32 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20 85% = \$453.60 Extended Medicare Safety Net Cap: \$426.90	
	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-p with or without either ligation or stripping, or both, of the long or short sapheno time on the same leg, including excision or injection of either tributaries or inco veins, or both (Anaes.) (Assist.)	us veins, for the first
32508	(See para TN.8.32 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20	
	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno leg - with or without either ligation or stripping, or both, of the long or short sap first time on the same leg, including excision or injection of either tributaries or veins, or both (Anaes.) (Assist.)	phenous veins, for the
32511	(See para TN.8.32 of explanatory notes to this Category) Fee: \$793.30 Benefit: 75% = \$595.00	
	VARICOSE VEINS, ligation of the long or short saphenous vein on the same le stripping, by re-operation for recurrent veins in the same territory - 1 leg - include of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
32514	(See para TN.8.32 of explanatory notes to this Category) Fee: \$926.80 Benefit: 75% = \$695.10	
	VARICOSE VEINS, ligation of the long and short saphenous vein on the same stripping, by re-operation for recurrent veins in either territory - 1 leg - including either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)	
32517	(See para TN.8.32 of explanatory notes to this Category) Fee: \$1,193.40 Benefit: 75% = \$895.05	

T8. SUR	GICAL OPERATIONS	3. VASCULAR
	Varicose veins, abolition of venous reflux by occlusion of a primary or recu (short) saphenous vein of one leg (and major tributaries of saphenous veins probe introduced by an endovenous catheter, if it is documented by duplex u small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5	as necessary), using a laser Iltrasound that the great or
	(a) including all preparation and immediate clinical aftercare (including excitation tributaries or incompetent perforating veins, or both); and	ision or injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyan	noacrylate embolisation; and
	(c) not provided on the same occasion as a service described in any of items 32507 (Anaes.)	32500, 32501, 32504 and
Amend 32520	(See para TN.8.33 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20 85% = \$453.60 Extended Medicare Safety Net Cap: \$80.05	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recu (short) saphenous vein of one leg (and major tributaries of saphenous veins a probe introduced by an endovenous catheter, if it is documented by duplex u small saphenous veins demonstrate reflux of 0.5 seconds or longer:	as necessary), using a laser
	(a) including all preparation and immediate clinical aftercare (including excititibutaries or incompetent perforating veins, or both); and	ision or injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyan not provided on the same occasion as a service described in any of items 32: 32507 (Anaes.)	
Amend 32522	(See para TN.8.33 of explanatory notes to this Category) Fee: \$793.30 Benefit: 75% = \$595.00 85% = \$711.60 Extended Medicare Safety Net Cap: \$79.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recu (short) saphenous vein of one leg (and major tributaries of saphenous veins a radiofrequency catheter introduced by an endovenous catheter, if it is docum that the great or small saphenous vein (whichever is to be treated) demonstra- longer:	as necessary), using a nented by duplex ultrasound
	(a) including all preparation and immediate clinical aftercare (including excititibutaries or incompetent perforating veins, or both); and	ision or injection of either
	(b) not including endovenous laser therapy or cyanoacrylate embolisation; a	nd
	(c) not provided on the same occasion as a service described in any of items 32507 (Anaes.)	32500, 32501, 32504 and
Amend 32523	(See para TN.8.33 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20 85% = \$453.60 Extended Medicare Safety Net Cap: \$80.05	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recu (short) saphenous vein of one leg (and major tributaries of saphenous veins radiofrequency catheter introduced by an endovenous catheter, if it is docun that the great and small saphenous veins demonstrate reflux of 0.5 seconds of	as necessary), using a nented by duplex ultrasound
Amend 32526	(a)including all preparation and immediate clinical aftercare (including excis	sion or injection of either

T8. SUR	GICAL OPERATIONS	3. VASCULAR
	tributaries or incompetent perforating veins, or both); and	
	(b) not including endovenous laser therapy or cyanoacrylate embolisation; and	
	(c) not provided on the same occasion as a service described in any of items 32500, 32507 (Anaes.)	32501, 32504 and
	(See para TN.8.33 of explanatory notes to this Category) Fee: \$793.30 Benefit: 75% = \$595.00 85% = \$711.60 Extended Medicare Safety Net Cap: \$79.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent gree (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessic cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great or sm (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer:	sary), using
	(a) including all preparation and immediate clinical aftercare (including excision or intributaries or incompetent perforating veins, or both); and	njection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous	laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32507	32501, 32504 and
	(Anaes.)	
New 32528 S	(See para TN.8.33, TN.8.2 of explanatory notes to this Category) Fee: \$533.60 Benefit: 75% = \$400.20 85% = \$453.60	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent gree (short) saphenous vein of one leg (and major tributaries of saphenous veins as necess cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and s veins demonstrate reflux of 0.5 seconds or longer:	sary), using
	(a) including all preparation and immediate clinical aftercare (including excision or intributaries or incompetent perforating veins, or both); and	njection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous	laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32507	32501, 32504 and
	(Anaes.)	
New 32529 S	(See para TN.8.33, TN.8.2 of explanatory notes to this Category) Fee: \$793.30 Benefit: 75% = \$595.00 85% = \$711.60	
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISE	\SE
	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.)	
32700	Fee: \$1,436.30 Benefit: 75% = \$1077.25	
	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)	small length and
32703	Fee: \$1,188.20 Benefit: 75% = \$891.15	
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anae	s.) (Assist.)

T8. SUF	RGICAL OPERATIO	ONS 3. VASCULAI
	Fee: \$1,421.35	Benefit: 75% = \$1066.05
	AORTIC BYPAS arteries (Anaes.) (S for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac Assist.)
32710	Fee: \$1,579.30	Benefit: 75% = \$1184.50
		S for occlusive disease using a bifurcated graft with 1 or both anastomoses to the or profunda femoris arteries (Anaes.) (Assist.)
32711	Fee: \$1,737.25	Benefit: 75% = \$1302.95
	ILIO-FEMORAL	BYPASS GRAFTING (Anaes.) (Assist.)
32712	Fee: \$1,255.80	Benefit: 75% = \$941.85
	AXILLARY or SI ARTERIES (Anac	JBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL es.) (Assist.)
32715	Fee: \$1,255.80	Benefit: 75% = \$941.85
	FEMORO-FEMO	RAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)
32718	Fee: \$1,188.20	Benefit: 75% = \$891.15
	RENAL ARTERY	, bypass grafting to (Anaes.) (Assist.)
32721	Fee: \$1,887.35	Benefit: 75% = \$1415.55
	RENAL ARTERI	ES (both), bypass grafting to (Anaes.) (Assist.)
32724	Fee: \$2,143.10	Benefit: 75% = \$1607.35
	MESENTERIC V	ESSEL (single), bypass grafting to (Anaes.) (Assist.)
32730	Fee: \$1,624.30	Benefit: 75% = \$1218.25
	MESENTERIC V	ESSELS (multiple), bypass grafting to (Anaes.) (Assist.)
32733	Fee: \$1,887.35	Benefit: 75% = \$1415.55
		ENTERIC ARTERY, operation on, when performed in conjunction with another intra- ar operation (Anaes.) (Assist.)
32736	Fee: \$413.55	Benefit: 75% = \$310.20
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the behanous vein) with above knee anastomosis (Anaes.) (Assist.)
32739	Fee: \$1,293.40	Benefit: 75% = \$970.05
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the behavior of when it is the behavior of the behavi
32742	Fee: \$1,481.50	Benefit: 75% = \$1111.15
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the phenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal ssist.)
32745	Fee: \$1,691.95	Benefit: 75% = \$1269.00
32748	FEMORAL ART	ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the

T8. SUR	GICAL OPERATIONS	3. VASCULAR
	ipsilateral long saphenous vein) with distal anastomosis wi	thin 5cms of the ankle joint (Anaes.) (Assist.)
	Fee: \$1,834.80 Benefit: 75% = \$1376.10	
	FEMORAL ARTERY BYPASS GRAFTING using synthe below the knee (Anaes.) (Assist.)	tic graft, with lower anastomosis above or
32751	Fee: \$1,188.20 Benefit: 75% = \$891.15	
	FEMORAL ARTERY BYPASS GRAFTING, using a com lower anastomosis above or below the knee, including use anastomoses (Anaes.) (Assist.)	
32754	Fee: \$1,481.50 Benefit: 75% = \$1111.15	
	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTE an additional anastomosis is made to separately revasculari revascularised beyond a femoral bypass (Anaes.) (Assist.)	
32757	Fee: \$413.55 Benefit: 75% = \$310.20	
	VEIN, HARVESTING OF, FROM LEG OR ARM for byp on the limb which is the subject of the bypass or graft - eac	
32760	Fee: \$406.05 Benefit: 75% = \$304.55	
	ARTERIAL BYPASS GRAFTING, using vein or synthetic another item in this Sub-group applies (Anaes.) (Assist.)	c material, not being a service to which
32763	Fee: \$1,188.20 Benefit: 75% = \$891.15	
	ARTERIAL OR VENOUS ANASTOMOSIS, not being a group applies, as an independent procedure (Anaes.) (Assis	
32766	Fee: \$789.65 Benefit: 75% = \$592.25	
	ARTERIAL OR VENOUS ANASTOMOSIS not being a s group applies, when performed in combination with anothe anastomosis) (Anaes.) (Assist.)	
32769	Fee: \$273.65 Benefit: 75% = \$205.25	
	BYPASS, REPLACEMENT, LIGAT	ION OF ANEURYSMS
	BYPASS GRAFTING to replace a popliteal aneurysm usin the ipsilateral long saphenous vein) (Anaes.) (Assist.)	ng vein, including harvesting vein (when it is
33050	Fee: \$1,455.30 Benefit: 75% = \$1091.50	
	BYPASS GRAFTING to replace a popliteal aneurysm usir	ng a synthetic graft (Anaes.) (Assist.)
33055	Fee: \$1,167.05 Benefit: 75% = \$875.30	
	ANEURYSM IN THE EXTREMITIES, ligation, suture cle (Anaes.) (Assist.)	osure or excision of, without bypass grafting
33070	Fee: \$842.00 Benefit: 75% = \$631.50 85% = \$760.3	30
	ANEURYSM IN THE NECK, ligation, suture closure or e (Assist.)	
	Fee: \$1,071.05 Benefit: 75% = \$803.30	

T8. SUF	GICAL OPERATIONS	3. VASCULAR
	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture of bypass grafting (Anaes.) (Assist.)	closure or excision of, without
33080	Fee: \$1,307.45 Benefit: 75% = \$980.60	
	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY of vein or synthetic material (Anaes.) (Assist.)	, OR BOTH, replacement by graft
33100	Fee: \$1,436.30 Benefit: 75% = \$1077.25 85% = \$1354.60	
	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	
33103	Fee: \$2,015.30 Benefit: 75% = \$1511.50	
	THORACO-ABDOMINAL ANEURYSM, replacement by graft incl (Anaes.) (Assist.)	uding re-implantation of arteries
33109	Fee: \$2,436.50 Benefit: 75% = \$1827.40 85% = \$2354.80	
	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement of arteries (Anaes.) (Assist.)	nt by graft including re-implantation
33112	Fee: \$2,113.10 Benefit: 75% = \$1584.85	
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacemen associated with a service to which item 33116 applies (Anaes.) (Assis	
33115	Fee: \$1,421.35 Benefit: 75% = \$1066.05	
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacemen repair procedure, excluding associated radiological services (Anaes.)	
33116	Fee: \$1,399.00 Benefit: 75% = \$1049.25 85% = \$1317.30	
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacemen arteries (with or without excision of common iliac aneurysms) not be service to which item 33119 applies (Anaes.) (Assist.)	
33118	Fee: \$1,579.30 Benefit: 75% = \$1184.50	
	 INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or b iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) 	
33119	Fee: \$1,554.55 Benefit: 75% = \$1165.95 85% = \$1472.85	
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacemen femoral arteries (with or without excision or bypass of common iliac	
33121	Fee: \$1,737.25 Benefit: 75% = \$1302.95	
	ANEURYSM OF ILIAC ARTERY (common, external or internal), r (Anaes.) (Assist.)	eplacement by graft - unilateral
33124	Fee: \$1,210.80 Benefit: 75% = \$908.10	
	ANEURYSMS OF ILIAC ARTERIES (common, external or internal (Anaes.) (Assist.)	l), replacement by graft - bilateral
33127	Fee: \$1,586.75 Benefit: 75% = \$1190.10 85% = \$1505.05	
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by dire	ct anastomosis or replacement by

T8. SUF	RGICAL OPERATIO	ONS 3. VASCULAR
	graft (Anaes.) (As	sist.)
	Fee: \$1,383.65	Benefit: 75% = \$1037.75
	ANEURYSM OF continuity (Anaes	VISCERAL ARTERY, dissection and ligation of arteries without restoration of .) (Assist.)
33133	Fee: \$1,037.65	Benefit: 75% = \$778.25
	FALSE ANEURY (Assist.)	SM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.)
33136	Fee: \$2,616.75	Benefit: 75% = \$1962.60
	FALSE ANEURY	/SM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.)
33139	Fee: \$1,586.75	Benefit: 75% = \$1190.10
	FALSE ANEURY	/SM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)
33142	Fee: \$1,481.50	Benefit: 75% = \$1111.15 85% = \$1399.80
	RUPTURED THO	DRACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)
33145	Fee: \$2,549.20	Benefit: 75% = \$1911.90
	RUPTURED THO (Assist.)	DRACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)
33148	Fee: \$3,165.80	Benefit: 75% = \$2374.35
	RUPTURED SUP (Assist.)	PRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)
33151	Fee: \$3,007.90	Benefit: 75% = \$2255.95
	RUPTURED INF (Anaes.) (Assist.)	RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft
33154	Fee: \$2,225.90	Benefit: 75% = \$1669.45
		RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft ith or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)
33157	Fee: \$2,481.50	Benefit: 75% = \$1861.15
		RARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft ral arteries (Anaes.) (Assist.)
33160	Fee: \$2,481.50	Benefit: 75% = \$1861.15
	RUPTURED ILIA	AC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)
33163	Fee: \$2,105.70	Benefit: 75% = \$1579.30
	RUPTURED ANI (Assist.)	EURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.)
33166	Fee: \$2,105.70	Benefit: 75% = \$1579.30 85% = \$2024.00
	RUPTURED ANI	EURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)
33169	Fee: \$1,639.35	Benefit: 75% = \$1229.55

T8. SUF	. SURGICAL OPERATIONS 3. VAS		3. VASCULAR
		MAJOR ARTERY, replacement by graft, not bein plies (Anaes.) (Assist.)	ng a service to which another item in
33172	Fee: \$1,278.35	Benefit: 75% = \$958.80	
	RUPTURED ANI bypass grafting (A	EURYSM IN THE EXTREMITIES, ligation, sutu .naes.) (Assist.)	re closure or excision of, without
33175	Fee: \$1,178.10	Benefit: 75% = \$883.60	
	RUPTURED ANI grafting (Anaes.)	EURYSM IN THE NECK, ligation, suture closure Assist.)	or excision of, without bypass
33178	Fee: \$1,498.20	Benefit: 75% = \$1123.65	
		RA-ABDOMINAL OR PELVIC ANEURYSM, 1 afting (Anaes.) (Assist.)	igation, suture closure or excision of,
33181	Fee: \$1,831.70	Benefit: 75% = \$1373.80	
		ENDARTERECTOMY AND ARTERIAL	PATCH
		TERIES OF NECK, endarterectomy of, including 1 or more arteries is undertaken through 1 arterio	
33500	Fee: \$1,135.40	Benefit: 75% = \$851.55	
	INNOMINATE C (Assist.)	R SUBCLAVIAN ARTERY, endarterectomy of,	including closure by suture (Anaes.)
33506	Fee: \$1,270.90	Benefit: 75% = \$953.20	
		TERECTOMY, including closure by suture, not b on the aorta (Anaes.) (Assist.)	being a service associated with
33509	Fee: \$1,421.35	Benefit: 75% = \$1066.05	
		NDARTERECTOMY (1 or both iliac arteries), in with a service to which item 33515 applies (Anae	e . e
33512	Fee: \$1,579.30	Benefit: 75% = \$1184.50	
	FEMORAL END	AL ENDARTERECTOMY (1 or both femoral art ARTERECTOMY, including closure by suture, no em 33512 applies (Anaes.) (Assist.)	
33515	Fee: \$1,737.25	Benefit: 75% = \$1302.95	
		ERECTOMY, including closure by suture, not bei liac artery (Anaes.) (Assist.)	ng a service associated with another
33518	Fee: \$1,270.90	Benefit: 75% = \$953.20 85% = \$1189.20	
	ILIO-FEMORAL	ENDARTERECTOMY (1 side), including closur	e by suture (Anaes.) (Assist.)
33521	Fee: \$1,376.10	Benefit: 75% = \$1032.10	
	RENAL ARTERY	, endarterectomy of (Anaes.) (Assist.)	
33524	Fee: \$1,624.30	Benefit: 75% = \$1218.25	
		ES (both), endarterectomy of (Anaes.) (Assist.)	
33527	Fee: \$1,887.35	Benefit: 75% = \$1415.55	
55521	1'CC. \$1,007.33	Denetit. $1370 = \phi1413.33$	

T8. SUF	GICAL OPERATIONS	3. VASCULAR
	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (A	Anaes.) (Assist.)
33530	Fee: \$1,624.30 Benefit: 75% = \$1218.25	
	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of	(Anaes.) (Assist.)
33533	Fee: \$1,887.35 Benefit: 75% = \$1415.55	
	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a servic to which another item in this Sub-group applies (Anaes.) (Assist.)	e associated with a service
33536	Fee: \$1,346.10 Benefit: 75% = \$1009.60	
	ARTERY OF EXTREMITIES, endarterectomy of, including closure by sutu	re (Anaes.) (Assist.)
33539	Fee: \$970.05 Benefit: 75% = \$727.55	
	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarter (Anaes.) (Assist.)	ectomy is at least 7cms long
33542	Fee: \$1,383.65 Benefit: 75% = \$1037.75	
	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthet less than 3cm long (Anaes.) (Assist.)	ic material where patch is
33545	(See para TN.8.36 of explanatory notes to this Category) Fee: \$273.65 Benefit: 75% = \$205.25	
	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthet 3cm long or greater (Anaes.) (Assist.)	ic material where patch is
33548	(See para TN.8.36 of explanatory notes to this Category)Fee: $$556.60$ Benefit: $75\% = 417.45	
	VEIN, harvesting of from leg or arm for patch when not performed through s (Anaes.) (Assist.)	same incision as operation
33551	(See para TN.8.36 of explanatory notes to this Category)Fee: $$273.65$ Benefit: $75\% = 205.25	
	ENDARTERECTOMY, in conjunction with an arterial bypass operation to p anastomosis - each site (Anaes.) (Assist.)	prepare the site for
33554	Fee: \$272.40 Benefit: 75% = \$204.30	
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR	TRAUMA
	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.)	
33800	Fee: \$1,180.60 Benefit: 75% = \$885.45 85% = \$1098.90	
	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an a trunk (Anaes.) (Assist.)	rtery or bypass graft of
33803	Fee: \$1,128.05 Benefit: 75% = \$846.05	
	Embolectomy or thrombectomy (including the infusion of thrombolytic or of or bypass graft of extremities, or embolectomy of abdominal artery via the fe claimed once per extremity, regardless of the number of incisions required to graft (Anaes.) (Assist.)	emoral artery, item to be
33806	Fee: \$812.15 Benefit: 75% = \$609.15 85% = \$730.45	
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by cathe	ter via the femoral vein

T8. SUF	GICAL OPERATIO	NS 3. VASCULA
	(Anaes.) (Assist.)	
	Fee: \$592.45	Benefit: 75% = \$444.35 85% = \$510.75
	INFERIOR VENA	CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.)
33811	Fee: \$1,763.80	Benefit: 75% = \$1322.85
	THROMBUS, rem	oval of, from femoral or other similar large vein (Anaes.) (Assist.)
33812	Fee: \$932.45	Benefit: 75% = \$699.35 85% = \$850.75
	MAJOR ARTERY lateral suture (Ana	OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by es.) (Assist.)
33815	Fee: \$857.30	Benefit: 75% = \$643.00
	MAJOR ARTERY direct anastomosis	OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by (Anaes.) (Assist.)
33818	Fee: \$1,000.15	Benefit: 75% = \$750.15
		OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by of synthetic material or vein (Anaes.) (Assist.)
33821	Fee: \$1,143.00	Benefit: 75% = \$857.25
	MAJOR ARTERY suture (Anaes.) (A	OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral ssist.)
33824	Fee: \$1,090.35	Benefit: 75% = \$817.80
	MAJOR ARTERY anastomosis (Anae	OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct s.) (Assist.)
33827	Fee: \$1,278.35	Benefit: 75% = \$958.80
		OR VEIN OF NECK, repair of wound of, with restoration of continuity, by of synthetic material or vein (Anaes.) (Assist.)
33830	Fee: \$1,466.30	Benefit: 75% = \$1099.75
	MAJOR ARTERY lateral suture (Ana	OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by es.) (Assist.)
33833	Fee: \$1,331.15	Benefit: 75% = \$998.40
	MAJOR ARTERY direct anastomosis	OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by (Anaes.) (Assist.)
33836	Fee: \$1,586.75	Benefit: 75% = \$1190.10
		OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by ion graft (Anaes.) (Assist.)
33839	Fee: \$1,857.40	Benefit: 75% = \$1393.05
	ARTERY OF NEO (Anaes.) (Assist.)	CK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery
33842	Fee: \$917.40	Benefit: 75% = \$688.05
33845	LAPAROTOMY f	or control of post operative bleeding or thrombosis after intra-abdominal vascular

T8. SUR	GICAL OPERATIONS	3. VASCULAR	
	procedure, where no other procedure is performed (Anaes.) (Assist.)		
	Fee: \$639.20 Benefit: 75% = \$479.40		
	EXTREMITY, re-operation on, for control of bleeding or thrombosis other procedure is performed (Anaes.) (Assist.)	s after vascular procedure, where no	
33848	Fee: \$639.20 Benefit: 75% = \$479.40		
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPR	RESSION OF VESSELS	
	MAJOR ARTERY OF NECK, elective ligation or exploration of, no any other vascular procedure (Anaes.) (Assist.)	t being a service associated with	
34100	Fee: \$707.00 Benefit: 75% = \$530.25		
	Great artery (aorta or pulmonary artery) or great vein (superior or inf exploration of immediate branches or tributaries, or ligation or explo iliac, femoral or popliteal arteries or veins, if the service is not associ 32520, 32522, 32523, 32526, 32528 or 32529 - for a maximum of 2 patient on the same occasion (H) (Anaes.) (Assist.)	ration of the subclavian, axillary, iated with item 32508, 32511,	
Amend 34103	(See para TN.8.2 of explanatory notes to this Category) Fee: \$413.55 Benefit: 75% = \$310.20		
	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation exploration of, not being a service associated with any other vascular procedure except those se which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.)		
	Fee: \$291.70 Benefit: 75% = \$218.80 85% = \$247.95		
34106			
	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.)		
34109	Fee: \$338.35 Benefit: 75% = \$253.80 85% = \$287.60		
	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection a	nd ligation (Anaes.) (Assist.)	
34112	Fee: \$857.30 Benefit: 75% = \$643.00		
	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation	ation (Anaes.) (Assist.)	
34115	Fee: \$970.05 Benefit: 75% = \$727.55		
	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and	nd ligation (Anaes.) (Assist.)	
34118	Fee: \$1,383.65 Benefit: 75% = \$1037.75 85% = \$1301.95		
-	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection a continuity (Anaes.) (Assist.)	nd repair of, with restoration of	
34121	Fee: \$1,105.35 Benefit: 75% = \$829.05		
	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and rep (Anaes.) (Assist.)	air of, with restoration of continuity	
34124	Fee: \$1,210.80 Benefit: 75% = \$908.10		
	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection an continuity (Anaes.) (Assist.)	nd repair of, with restoration of	
34127	Fee: \$1,586.75 Benefit: 75% = \$1190.10		
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN	NEXTREMITY, closure of (Anaes.)	

T8. SUF	RGICAL OPERAT	ONS 3. VASCULAR
	(Assist.)	
	Fee: \$496.30	Benefit: 75% = \$372.25 85% = \$421.90
	SCALENOTOM	Y (Anaes.) (Assist.)
34133	Fee: \$556.60	Benefit: 75% = \$417.45
	FIRST RIB, rese	ction of portion of (Anaes.) (Assist.)
34136	Fee: \$894.75	Benefit: 75% = \$671.10
		, removal of, or other operation for removal of thoracic outlet compression, not being a another item in this Sub-group applies (Anaes.) (Assist.)
34139	Fee: \$894.75	Benefit: 75% = \$671.10
	COELIAC ARTI	ERY, decompression of, for coeliac artery compression syndrome, as an independent a.) (Assist.)
34142	Fee: \$1,105.35	Benefit: 75% = \$829.05
		TERY, exploration of, for popliteal entrapment, with or without division of fibrous (Anaes.) (Assist.)
34145	Fee: \$804.65	Benefit: 75% = \$603.50
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.)
34148	Fee: \$1,436.30	Benefit: 75% = \$1077.25
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)
34151	Fee: \$1,962.65	Benefit: 75% = \$1472.00
		AROTID ASSOCIATED TUMOUR, resection of, with or without repair or ortion of internal or common carotid arteries (Anaes.) (Assist.)
34154	Fee: \$2,338.75	Benefit: 75% = \$1754.10 85% = \$2257.05
	NECK, excision	of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)
34157	Fee: \$1,188.20	Benefit: 75% = \$891.15
	AORTO-DUOD (Assist.)	ENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.)
34160	Fee: \$2,225.90	Benefit: 75% = \$1669.45
	AORTO-DUOD (Anaes.) (Assist.)	ENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum
34163	Fee: \$2,857.55	Benefit: 75% = \$2143.20
		ENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and grafting (Anaes.) (Assist.)
34166	Fee: \$2,857.55	Benefit: 75% = \$2143.20
	INFECTED BYE (Assist.)	ASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.)
34169		

T8. SUF	IRGICAL OPERATIONS		3. VASCULAR	
	Fee: \$1,586.75	Benefit: 75% = \$1190.10		
	INFECTED AXIL arteries (Anaes.) (LO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision Assist.)	of, including closure of	
34172	Fee: \$1,293.40	Benefit: 75% = \$970.05		
	INFECTED BYPA (Anaes.) (Assist.)	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.)		
34175	Fee: \$1,188.20	Benefit: 75% = \$891.15		
		OPERATIONS FOR VASCULAR ACCESS		
	ARTERIOVENO	US SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.)		
34500	Fee: \$308.40	Benefit: 75% = \$231.30 85% = \$262.15		
		US ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunoperation (Anaes.) (Assist.)	nction with another	
34503	Fee: \$413.55	Benefit: 75% = \$310.20		
	ARTERIOVENO	US SHUNT, EXTERNAL, removal of (Anaes.) (Assist.)		
34506	Fee: \$210.45	Benefit: 75% = \$157.85		
		US ANASTOMOSIS OF UPPER OR LOWER LIMB, not in co arterial operation (Anaes.) (Assist.)	onjunction with	
34509	Fee: \$977.55	Benefit: 75% = \$733.20		
	ARTERIOVENO	US ACCESS DEVICE, insertion of (Anaes.) (Assist.)		
34512	Fee: \$1,075.40	Benefit: 75% = \$806.55		
	ARTERIOVENO	US ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.)		
34515	Fee: \$767.00	Benefit: 75% = \$575.25		
	STENOSIS OF A	RTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVE on of (Anaes.) (Assist.)	ENOUS ACCESS	
34518	Fee: \$1,285.75	Benefit: 75% = \$964.35		
		INAL ARTERY OR VEIN, cannulation of, for infusion chemoting aftercare) (Anaes.) (Assist.)	herapy, by open	
34521	(See para TN.8.4 of Fee: \$789.95	explanatory notes to this Category) Benefit: 75% = \$592.50		
		NULATION for infusion chemotherapy by open operation, not applies (excluding after-care) (Anaes.) (Assist.)	being a service to	
34524	(See para TN.8.4 of Fee: \$413.55	explanatory notes to this Category) Benefit: 75% = \$310.20		
	access port as with	CATHETERISATION by open technique, using subcutaneous a central venous line catheter or other chemotherapy delivery de neous central vein catheterization, on a person 10 years of age of	vice, including any	
34527	(See para TN.8.2 of Fee: \$551.60	explanatory notes to this Category) Benefit: 75% = \$413.70 85% = \$469.90		

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcuta pump or access port as with central venous line catheter or other chemotherapy deli person 10 years of age or over (Anaes.)	
34528	(See para TN.8.2 of explanatory notes to this Category) Fee: \$272.40 Benefit: 75% = \$204.30 85% = \$231.55	
	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous to access port as with central venous line catheter or other chemotherapy delivery devia associated percutaneous central vein catheterization, on a person under 10 years of	ice, including any
34529	Fee: \$717.10 Benefit: 75% = \$537.85 85% = \$635.40	
	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal procedure in the operating theatre of a hospital on a person 10 years of age or over	
34530	(See para TN.8.2 of explanatory notes to this Category) Fee: \$204.25 Benefit: 75% = \$153.20 85% = \$173.65	
	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at comm procedure, regional perfusion for chemotherapy, or other therapy, repair of arterioto conclusion of procedure (excluding aftercare) (Anaes.) (Assist.)	
34533	Fee: \$1,240.65 Benefit: 75% = \$930.50 85% = \$1158.95	
	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcuta pump or access port as with central venous line catheter or other chemotherapy deli person under 10 years of age (Anaes.)	
34534	Fee: \$354.10 Benefit: 75% = \$265.60 85% = \$301.00	
	CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcu cuffed catheter or similar device, for the administration of haemodialysis or parente	
34538	Fee: \$272.40 Benefit: 75% = \$204.30 85% = \$231.55	
	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by op (Anaes.)	en surgical procedure
34539	Fee: \$204.25 Benefit: 75% = \$153.20 85% = \$173.65	
	CENTRAL VENOUS LINE, OR OTHER CHEMOTHERAPY DEVICE, removal procedure in the operating theatre of a hospital, on a person under 10 years of age (
34540	Fee: \$265.50 Benefit: 75% = \$199.15 85% = \$225.70	
	COMPLEX VENOUS OPERATIONS	
	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.)	(Assist.)
34800	Fee: \$812.15 Benefit: 75% = \$609.15 85% = \$730.45	
	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic materia	ıl (Anaes.) (Assist.)
34803	Fee: \$1,789.85 Benefit: 75% = \$1342.40	
	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (A	Assist.)
34806	Fee: \$970.05 Benefit: 75% = \$727.55	
	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vei (Assist.)	n bypass (Anaes.)
34809		

T8. SUF	RGICAL OPERATI	ONS	3. VASCULAR	
	Fee: \$970.05	Benefit: 75% = \$727.55		
		OSIS OR OCCLUSION, vein bypass for, using vein or synthe d with a service to which item 34806 or 34809 applies (Anaes.		
34812	Fee: \$1,173.05	Benefit: 75% = \$879.80		
	VEIN STENOSIS (Anaes.) (Assist.)	S, patch angioplasty for, (excluding vein graft stenosis)-using	vein or synthetic material	
34815	(See para TN.8.36 Fee: \$970.05	of explanatory notes to this Category) Benefit: 75% = \$727.55		
	VENOUS VALV	E, plication or repair to restore valve competency (Anaes.) (A	ssist.)	
34818	Fee: \$1,067.80	Benefit: 75% = \$800.85		
	VEIN TRANSPL	ANT to restore valvular function (Anaes.) (Assist.)		
34821	Fee: \$1,451.45	Benefit: 75% = \$1088.60 85% = \$1369.75		
		ENT, application of, to restore venous valve competency to su	perficial vein - 1 stent	
34824	Fee: \$496.30	Benefit: 75% = \$372.25		
		ENTS, application of, to restore venous valve competency to s (Anaes.) (Assist.)	uperficial vein or veins -	
34827	Fee: \$601.65	Benefit: 75% = \$451.25		
	EXTERNAL STI (Assist.)	ENT, application of, to restore venous valve competency to de-	ep vein (1 stent) (Anaes.)	
34830	Fee: \$707.00	Benefit: 75% = \$530.25 85% = \$625.30		
	EXTERNAL STI than 1 stent) (Ana	ENTS, application of, to restore venous valve competency to d aes.) (Assist.)	eep vein or veins (more	
34833	Fee: \$917.40	Benefit: 75% = \$688.05		
		SYMPATHECTOMY		
	LUMBAR SYMI	PATHECTOMY (Anaes.) (Assist.)		
35000	Fee: \$707.00	Benefit: 75% = \$530.25 85% = \$625.30		
	CERVICAL OR (Assist.)	UPPER THORACIC SYMPATHECTOMY by any surgical a	pproach (Anaes.)	
35003	Fee: \$917.40	Benefit: 75% = \$688.05		
	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.)			
35006	Fee: \$1,150.55	Benefit: 75% = \$862.95		
		PATHECTOMY, where operation is following chemical symp ete surgical sympathectomy (Anaes.) (Assist.)	athectomy or for	
35009	Fee: \$894.75	Benefit: 75% = \$671.10		
35012	SACRAL or PRE	E-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)		

T8. SUF	GICAL OPERAT	IONS	3. VASCULAR	
	Fee: \$707.00	Benefit: 75% = \$530.25		
		DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR I	DISEASE	
		IMB, debridement of necrotic material, gangrenous tissue, or ital, when debridement includes muscle, tendon or bone (An		
35100	Fee: \$368.55	Benefit: 75% = \$276.45		
		IMB, debridement of necrotic material, gangrenous tissue, or ital, superficial tissue only (Anaes.)	slough in, in the operating	
35103	Fee: \$234.55	Benefit: 75% = \$175.95		
		MISCELLANEOUS VASCULAR PROCEDURES		
		RTERIOGRAPHY OR VENOGRAPHY, 1 or more of, perfected ure on an artery or vein, 1 site (Anaes.)	ormed during the course of	
35200	Fee: \$171.50	Benefit: 75% = \$128.65		
		RIES OR VEINS IN THE NECK, ABDOMEN OR EXTREM N after prior surgery on these vessels (Anaes.) (Assist.)	MITIES, access to, as part of	
35202	Fee: \$817.10	Benefit: 75% = \$612.85		
		ENDOVASCULAR INTERVENTIONAL PROCEDUR	RES	
		AL BALLOON ANGIOPLASTY of 1 peripheral artery or v sure, excluding associated radiological services or preparatio .)		
35300	Fee: \$515.35	Benefit: 75% = \$386.55 85% = \$438.05		
	more than 1 peri	AL BALLOON ANGIOPLASTY of aortic arch branches, ac pheral artery or vein of 1 limb, percutaneous or by open exp vices or preparation, and excluding aftercare (Anaes.) (Assist	osure, excluding associated	
35303	Fee: \$660.80	Benefit: 75% = \$495.60 85% = \$579.10		
	peripheral artery	AL STENT INSERTION, 1 or more stents, including associate or vein of 1 limb, percutaneous or by open exposure, exclude aration, and excluding aftercare. (Anaes.) (Assist.)		
35306	(See para TN.8.2 Fee: \$609.90	of explanatory notes to this Category) Benefit: 75% = \$457.45 85% = \$528.20		
	associated ballo	AL STENT INSERTION, 1 or more stents (not drug-eluting on dilatation, for 1 carotid artery, percutaneous (not direct), v on device, in patients who:		
	- meet the indications for carotid endarterectomy; and			
		l or surgical comorbidities that would make them at high risk om carotid endarterectomy,	of perioperative	
	excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)			
35307	(See para TN.8.37 Fee: \$1,121.15	of explanatory notes to this Category) Benefit: 75% = \$840.90		
35309		AL STENT INSERTION, 1 or more stents, including association or veins, or more than 1 peripheral artery or vein of 1 limb, p		

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	exposure, excluding associated radiological services or preparation, and exclu (Assist.)	ding aftercare. (Anaes.)
	(See para TN.8.2 of explanatory notes to this Category) Fee: \$762.35 Benefit: 75% = \$571.80 85% = \$680.65	
	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon of percutaneous or by open exposure, excluding associated radiological services excluding aftercare (Anaes.) (Assist.)	
35312	Fee: \$864.05 Benefit: 75% = \$648.05	
	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatat or by open exposure, excluding associated radiological services or preparation (Anaes.) (Assist.)	
35315	Fee: \$864.05 Benefit: 75% = \$648.05	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with admin or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutane associated radiological services or preparation, and excluding aftercare (not be with a service to which another item in Subgroup 11 of Group T1 or items 352 not being a service associated with photodynamic therapy with verteporfin) (A	eous approach, excluding eing a service associated 319 or 35320 applies and
35317	(See para TN.8.38 of explanatory notes to this Category) Fee: \$355.80 Benefit: 75% = \$266.85 85% = \$302.45	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with admin or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percuta excluding associated radiological services or preparation, and excluding after associated with a service to which another item in Subgroup 11 of Group T1 of applies and not being a service associated with photodynamic therapy with ve (Assist.)	aneous approach, care (not being a service or items 35317 or 35320
35319	Fee: \$637.80 Benefit: 75% = \$478.35 85% = \$556.10	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with admin or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated rad preparation, and excluding aftercare (not being a service associated with a ser in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a photodynamic therapy with verteporfin) (Anaes.) (Assist.)	diological services or vice to which another item
35320	Fee: \$856.70 Benefit: 75% = \$642.55 85% = \$775.00	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to adminis arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for fibroids or varicose veins) percutaneous or by open exposure, excluding assoc or preparation, and excluding aftercare, not being a service associated with ph verteporfin (Anaes.) (Assist.)	the treatment of uterine ciated radiological services
35321	(See para TN.8.39 of explanatory notes to this Category) Fee: \$813.30 Benefit: 75% = \$610.00 85% = \$731.60	
	ANGIOSCOPY not combined with any other procedure, excluding associated preparation, and excluding aftercare (Anaes.) (Assist.)	l radiological services or
35324	Fee: \$304.95 Benefit: 75% = \$228.75	
35327	ANGIOSCOPY combined with any other procedure, excluding associated rad	liological services or

T8. SUF	GICAL OPERATIONS	3. VASCULAR
	preparation, and excluding aftercare (Anaes.) (Assist.)	
	Fee: \$408.70 Benefit: 75% = \$306.55	
	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous associated radiological services or preparation, and excluding aftercar	
35330	Fee: \$515.35 Benefit: 75% = \$386.55 85% = \$438.05	
	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneou including associated radiological services or preparation, and not include	
35331	Fee: \$592.45 Benefit: 75% = \$444.35	
	Retrieval of foreign body in PULMONARY ARTERY, percutaneous associated radiological services or preparation, and not including afte	
	(foreign body does not include an instrument inserted for the purpose (Anaes.) (Assist.)	e of a service being rendered)
35360	Fee: \$828.20 Benefit: 75% = \$621.15	
	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by op associated radiological services or preparation, and not including after	
	(foreign body does not include an instrument inserted for the purpose (Anaes.) (Assist.)	e of a service being rendered)
35361	Fee: \$710.30 Benefit: 75% = \$532.75	
	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, p not including associated radiological services or preparation, and not	
	(foreign body does not include an instrument inserted for the purpose (Anaes.) (Assist.)	e of a service being rendered)
35362	Fee: \$592.45 Benefit: 75% = \$444.35	
	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL exposure, not including associated radiological services or preparatio	
	(foreign body does not include an instrument inserted for the purpose (Anaes.) (Assist.)	e of a service being rendered)
35363	Fee: \$474.65 Benefit: 75% = \$356.00	
	INTERVENTIONAL RADIOLOGY PROCE	EDURES
35404	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES therapy of hepatic metastases which are secondary to colorectal cance or ablation, used in combination with systemic chemotherapy using 5	er and are not suitable for resection

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	not being a service to which item 35317, 35319, 35320 or 35321 applies	
	The procedure must be performed by a specialist or consultant physician recognis nuclear medicine or radiation oncology on an admitted patient in a hospital. To be patient's lifetime only.	
	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$346.60 Benefit: 75% = \$259.95	
	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to e microvasculature of hepatic metastases which are secondary to colorectal cancer a resection or ablation, for selective internal radiation therapy used in combination chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to w 35319, 35320 or 35321 applies	and are not suitable for with systemic
	excluding associated radiological services or preparation, and excluding aftercare	(Anaes.) (Assist.)
35406	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$813.30 Benefit: 75% = \$610.00	
	Catheterisation of the hepatic artery via a permanently implanted hepatic artery per Spheres to embolise the microvasculature of hepatic metastases which are second and are not suitable for resection or ablation, for selective internal radiation therap with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being item 35317, 35319, 35320 or 35321 applies	ary to colorectal cancer py used in combination
	excluding associated radiological services or preparation, and excluding aftercare	(Anaes.) (Assist.)
35408	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$610.10 Benefit: 75% = \$457.60	
	UTERINE ARTERY CATHETERISATION with percutaneous administration of the treatment of symptomatic uterine fibroids in a patient who has been referred f embolisation by a specialist gynaecologist, excluding associated radiological serv excluding aftercare (Anaes.) (Assist.)	or uterine artery
35410	(See para TN.8.34 of explanatory notes to this Category) Fee: \$813.30 Benefit: 75% = \$610.00 85% = \$731.60	
	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detac assisted coiling if performed, with parent artery preservation, not for use with liqu including aftercare, including intra-operative imaging, but in association with the operative diagnostic imaging items:	id embolics only,
	- either 60009 or 60010; and	
	- either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.)	
35412	(See para TN.8.35 of explanatory notes to this Category) Fee: \$2,857.55 Benefit: 75% = \$2143.20 85% = \$2775.85	
	Mechanical thrombectomy, in a patient with a diagnosis of acute ischaemic stroke of a large vessel of the anterior cerebral circulation, including intra-operative ima	
	(a) the diagnosis is confirmed by an appropriate imaging modality such as compu- magnetic resonance imaging or angiography; and	ted tomography,
35414	(b) the service is performed by a specialist or consultant physician with appropria recognised by the Conjoint Committee for Recognition of Training in Intervention	

T8. SUF	RGICAL OPERA	TIONS	3. VASCULAR
	and		
	(c) the service i	s provided in an eligible stroke centre.	
		lar patient - applicable once per presentation by e number of times mechanical thrombectomy is t.)	
	(See para TR.8.1 Fee: \$3,500.00	of explanatory notes to this Category) Benefit: 75% = \$2625.00	
T8. SUF	GICAL OPERA	TIONS	4. GYNAECOLOGICAL
	Group T8. Sur	gical Operations	
		Subgroup 4. Gynaecolo	ogical
		GICAL EXAMINATION UNDER ANAESTH ich another item in this Group applies (Anaes.)	ESIA, not being a service associated with
35500	Fee: \$81.30	Benefit: 75% = \$61.00 85% = \$69.15	
	ENDOMETRI	NE DEVICE, INTRODUCTION OF, for the co AL BIOPSY to exclude endometrial pathology, h another item in this Group applies (Anaes.)	
35502	Fee: \$80.15	Benefit: 75% = \$60.15 85% = \$68.15	
		ntraceptive device, introduction of, if the servic this Group applies (other than a service mentio	
35503	Fee: \$53.55	Benefit: 75% = \$40.20 85% = \$45.55	
		NE CONTRACEPTIVE DEVICE, REMOVAL A, not being a service associated with a service)	
35506	Fee: \$53.70	Benefit: 75% = \$40.30 85% = \$45.65	
	nerve block (ex	VAGINAL WARTS, removal of under general cluding pudendal block) requiring admission to 45 minutes - not being a service associated wit)	a hospital, where the time taken is less
35507	Fee: \$174.45	Benefit: 75% = \$130.85 85% = \$148.30	
	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or finerve 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 32 applies (Anaes.) (Assist.)		
35508	Fee: \$256.95	Benefit: 75% = \$192.75 85% = \$218.45	
	HYMENECTO	OMY (Anaes.)	
35509	Fee: \$89.45	Benefit: 75% = \$67.10 85% = \$76.05	
		S CYST, excision of (Anaes.)	
	Fee: \$221.70	Benefit: 75% = \$166.30 85% = \$188.45	

T8. SUR	GICAL OPERATIONS	4. GYNAECOLOGICAL	
	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.)		
35517	Fee: \$146.00 Benefit: 75% = \$109.50 85% = \$124.10		
	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in least 2cm in diameter in a postmenopausal person, by abdominal or vagin imaging techniques and not associated with services provided for assisted (Anaes.)	nal route, using interventional	
35518	(See para TN.4.11, TN.8.2 of explanatory notes to this Category) Fee: \$207.85 Benefit: 75% = \$155.90 85% = \$176.70		
	BARTHOLIN'S ABSCESS, incision of (Anaes.)		
35520	Fee: \$58.30 Benefit: 75% = \$43.75 85% = \$49.60		
	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.)		
35523	Fee: \$58.30 Benefit: 75% = \$43.75 85% = \$49.60		
	URETHRAL CARUNCLE, excision of (Anaes.)		
35527	Fee: \$146.00 Benefit: 75% = \$109.50 85% = \$124.10		
	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.)		
35530	Fee: \$269.85 Benefit: 75% = \$202.40		
	VULVOPLASTY or LABIOPLASTY, for repair of:		
	(a) female genital mutilation; or		
	(b) anomalies associated with major congenital anomalies of the uro-gy service associated with a service to which item 35536, 37050, 37836, 3		
	(H) (Anaes.)		
	(See para TN.8.123 of explanatory notes to this Category) Fee: \$349.85 Benefit: 75% = \$262.40		
35533	Extended Medicare Safety Net Cap: \$279.90		
	VULVOPLASTY or LABIOPLASTY, for localised gigantism if it can b	e demonstrated that:	
	(a) the structural abnormality is causing significant functional impairme	ent; and	
	(b) non-surgical treatments have failed		
	(H) (Anaes.)		
35534	(See para TN.8.123 of explanatory notes to this Category) Fee: \$349.85 Benefit: 75% = \$262.40		
	VULVA, wide local excision of suspected malignancy or hemivulvecton (Anaes.) (Assist.)	ny, 1 or both procedures	
35536	Fee: \$348.45 Benefit: 75% = \$261.35 85% = \$296.20		
	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for previo neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, inc biopsies 1 anatomical site (Anaes.)		
35539	Fee: \$272.95 Benefit: 75% = \$204.75 85% = \$232.05		

T8. SUR	GICAL OPERA	FIONS	4. GYNAECOLOGICAL
	neoplastic char	CALLY DIRECTED CO ² LASER THERAI ages of the cervix, vagina, vulva, urethra or a nore anatomical sites (Anaes.) (Assist.)	
35542	Fee: \$319.60	Benefit: 75% = \$239.70 85% = \$271.70	0
	COLPOSCOPIO by other method		PY for condylomata, unsuccessfully treated
35545	Fee: \$183.60	Benefit: 75% = \$137.70 85% = \$156.10	0
	VULVECTOM	Y, radical, for malignancy (Anaes.) (Assist.)
35548	Fee: \$834.05	Benefit: 75% = \$625.55	
	PELVIC LYM	PH GLANDS, excision of (radical) (Anaes.)	(Assist.)
35551	Fee: \$683.90	Benefit: 75% = \$512.95	
	VAGINA, DIL (Anaes.)	ATATION OF, as an independent procedure	e including any associated consultation
35554	Fee: \$43.50	Benefit: 75% = \$32.65 85% = \$37.00	
	VAGINA, remo	oval of simple tumour (including Gartner du	ct cyst) (Anaes.)
35557	Fee: \$214.50	Benefit: 75% = \$160.90 85% = \$182.3:	5
	VAGINA, parti	al or complete removal of (Anaes.) (Assist.))
35560	Fee: \$683.90	Benefit: 75% = \$512.95	
55500		AY, radical, for proven invasive malignancy	7 - 1 surgeon (Anaes.) (Assist.)
35561	Fee: \$1,379.50	Benefit: 75% = \$1034.65	
33301	VAGINECTON	AY, radical, for proven invasive malignancy care) (Anaes.) (Assist.)	v, conjoint surgery - abdominal surgeon
35562	Fee: \$1,132.60	Benefit: 75% = \$849.45	
		IY, radical, for proven invasive malignancy	v, conjoint surgery - perineal surgeon (Assist.)
35564	Fee: \$522.85	Benefit: 75% = \$392.15	
55501		CONSTRUCTION for congenital absence, g	gynatresia or urogenital sinus (Anaes.)
35565	Fee: \$683.90	Benefit: 75% = \$512.95	
	VAGINAL SEI	TUM, excision of, for correction of double	vagina (Anaes.) (Assist.)
35566	Fee: \$397.25	Benefit: 75% = \$297.95	
-			OF UPPER VAGINAL PROLAPSE (Anaes.)
35568	Fee: \$624.60	Benefit: 75% = \$468.45	
		AIR TO ENLARGE VAGINAL ORIFICE ((Anaes.)
35569	Fee: \$160.85	Benefit: 75% = \$120.65 85% = \$136.75	
22202		AGINAL COMPARTMENT REPAIR by va	

T8. SUR	GICAL OPERATI	ONS	4. GYNAECOLOGICAL
		cystocoele) with or without mesh, not b 3, 35577 or 35578 applies (Anaes.) (As	being a service associated with a service to sist.)
	Fee: \$553.85	Benefit: 75% = \$415.40	
	the following; rep		by vaginal approach (involving one or more of bele) with or without mesh, not being a service 35578 applies (Anaes.) (Assist.)
35571	Fee: \$553.85	Benefit: 75% = \$415.40	
	COLPOTOMY 1	not being a service to which another iter	m in this Group applies (Anaes.)
35572	Fee: \$123.80	Benefit: 75% = \$92.85	
	(involving both a	D POSTERIOR VAGINAL COMPAR' nterior and posterior compartment defe service to which item 35577 or 35578	cts) with or without mesh, not being a service
35573	Fee: \$830.90	Benefit: 75% = \$623.20	
	MANCHESTER (Anaes.) (Assist.)		ION for genital prolapse, with or without mesh
35577	Fee: \$674.50	Benefit: 75% = \$505.90	
		ATION for genital prolapse, not being a his Subgroup applies (Anaes.) (Assist.)	a service associated with a service to which
35578	Fee: \$674.50	Benefit: 75% = \$505.90	
	FIXATION OF T	C OR ABDOMINAL PELVIC FLOOR THE UTEROSACRAL AND CARDIN. L FASCIA for symptomatic upper vag	AL LIGAMENTS TO RECTOVAGINAL AND
35595	Fee: \$1,155.00	Benefit: 75% = \$866.25	
	FISTULA BETW		ALIMENTARY TRACTS, repair of, not being Anaes.) (Assist.)
35596	Fee: \$683.90	Benefit: 75% = \$512.95	
		npartment and to sacrum for correction	re where graft or mesh secured to vault, anterior of symptomatic upper vaginal vault prolapse
35597	Fee: \$1,473.20	Benefit: 75% = \$1104.90	
		TINENCE, sling operation for, with or service to which item 30405 applies (A	without mesh or tape, not being a service (Anaes.) (Assist.)
35599	Fee: \$674.50	Benefit: 75% = \$505.90	
	procedure, with o		DOMINOVAGINAL operation for; abdominal of being a service associated with a service to
35602	Fee: \$674.50	Benefit: 75% = \$505.90	
35605	STRESS INCON	TINENCE, combined synchronous AB	DOMINOVAGINAL operation for; vaginal ot being a service associated with a service to

T8. SUF		IONS 4. GYNAECOLOGICAL	
	which item 304	05 applies (Assist.)	
	Fee: \$365.95	Benefit: 75% = \$274.50 85% = \$311.10	
		risation (other than by chemical means), ionisation, diathermy or biopsy of, with or n of cervix (Anaes.)	
35608	Fee: \$64.00	Benefit: 75% = \$48.00 85% = \$54.40	
		val of polyp or polypi, with or without dilatation of cervix, not being a service associated which item 35608 applies (Anaes.)	
35611	Fee: \$64.00	Benefit: 75% = \$48.00 85% = \$54.40	
	CERVIX, RESI	DUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.)	
35612	Fee: \$506.00	Benefit: 75% = \$379.50 85% = \$430.10	
	CERVIX, RESI	DUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.)	
35613	Fee: \$404.80	Benefit: 75% = \$303.60	
	abnormal cervic	N OF LOWER TRACT by a Hinselmanntype colposcope in a patient with a previous al smear screen result or a history of maternal ingestion of oestrogen or where a patient, cious signs of cancer, has been referred by another medical practitioner (Anaes.)	
35614	(See para TN.8.2, Fee: \$63.90	TN.8.42 of explanatory notes to this Category) Benefit: 75% = \$47.95 85% = \$54.35	
	VULVA, biops	of, when performed in conjunction with a service to which item 35614 applies	
35615	Fee: \$53.70	Benefit: 75% = \$40.30 85% = \$45.65	
	radiofrequency	M, endoscopic examination of and ablation of, by microwave or thermal balloon or electrosurgery, for chronic refractory menorrhagia including any hysteroscopy e same day, with or without uterine curettage (Anaes.)	
35616	Fee: \$449.60	Benefit: 75% = \$337.20	
	CERVIX, cone applies (Anaes.)	biopsy, amputation or repair of, other than a service to which item 35577 or 35578	
35618	Fee: \$218.00	Benefit: 75% = \$163.50 85% = \$185.30	
	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.)		
35620	Fee: \$53.35	Benefit: 75% = \$40.05 85% = \$45.35	
	including any h	M, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia esteroscopy performed on the same day, with or without uterine curettage, not being a ed with a service to which item 30390 applies (Anaes.)	
35622	Fee: \$602.45	Benefit: 75% = \$451.85	
		PIC RESECTION of myoma, or myoma and uterine septum resection (where both are owed by endometrial ablation by laser or diathermy (Anaes.)	
35623	Fee: \$819.25	Benefit: 75% = \$614.45	
25/25	where the patien	PY, including biopsy, performed by a specialist in the practice of his or her specialty t is referred to him or her for the investigation of suspected intrauterine pathology (with	
35626	or without local	anaesthetic), not being a service associated with a service to which item 35627 or 35630	

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	applies	
	(See para TN.8.43 of explanatory notes to this Category) Fee: \$82.80 Benefit: 75% = \$62.10 85% = \$70.40	
	HYSTEROSCOPY with dilatation of the cervix performed in being a service associated with a service to which item 35626	
35627	Fee: \$107.15 Benefit: 75% = \$80.40	
	HYSTEROSCOPY, with endometrial biopsy, performed in the a service associated with a service to which item 35626 or 35	
35630	Fee: \$183.00 Benefit: 75% = \$137.25	
	HYSTEROSCOPY with uterine adhesiolysis or polypectomy insertion of device for sterilisation) or removal of IUD which more of (Anaes.)	
35633	Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30	
	HYSTEROSCOPIC RESECTION of uterine septum followe diathermy (Anaes.)	ed by endometrial ablation by laser or
35634	Fee: \$685.70 Benefit: 75% = \$514.30 85% = \$604.00	
	HYSTEROSCOPY involving resection of the uterine septum	n (Anaes.)
35635	Fee: \$299.45 Benefit: 75% = \$224.60	
	HYSTEROSCOPY, involving resection of myoma, or resection both are performed) (Anaes.)	ion of myoma and uterine septum (where
35636	Fee: \$433.00 Benefit: 75% = \$324.75	
	LAPAROSCOPY, involving puncture of cysts, diathermy of of adhesions or similar procedure - 1 or more procedures with associated with any other laparoscopic procedure or hysterec	h or without biopsy - not being a service
35637	(See para TN.1.4 of explanatory notes to this Category) Fee: \$406.65 Benefit: 75% = \$305.00	
	COMPLICATED OPERATIVE LAPAROSCOPY, including of the following procedures; oophorectomy, ovarian cystecto salpingostomy, ablation of moderate or severe endometriosis or division of utero-sacral ligaments for significant dysmenor any other intraperitoneal or retroperitoneal procedure except	bmy, myomectomy, salpingectomy or requiring more than 1 hours operating time, rrhoea - not being a service associated with
35638	Fee: \$711.50 Benefit: 75% = \$533.65	
	UTERUS, CURETTAGE OF, with or without dilatation (inc miscarriage) under general anaesthesia, or under epidural or procedures to which item 35626, 35627 or 35630 applies, if p	spinal (intrathecal) nerve block, including
35640	(See para TN.8.44 of explanatory notes to this Category) Fee: \$183.00 Benefit: 75% = \$137.25	
35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RES following procedures, resection of the pelvic side wall includ tissue from the ureter, resection of the Pouch of Douglas, rese than 2 cms in diameter, dissection of bowel from uterus from	ling dissection of endometriosis or scar ection of an ovarian endometrioma greater

T8. SUF	RGICAL OPERATIONS 4. GYNAECOLOGI	CAL
	above: where the operating time exceeds 90 minutes (Anaes.) (Assist.)	
	Fee: \$1,242.65 Benefit: 75% = \$932.00	
	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCT CURETTAGE other than a service to which item 35640 applies, including procedures to which item 35626, 35627 or 35630 applies, if performed (Anaes.)	
35643	Fee: \$218.00 Benefit: 75% = \$163.50 85% = \$185.30	
	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, other than a service associated with a service to which item 35640 or 35647 applies (Anaes.)	
35644	(See para TN.8.45 of explanatory notes to this Category) Fee: \$203.65 Benefit: 75% = \$152.75 85% = \$173.15	
	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, uret or anus, not being a service associated with a service to which item 35648 applies (Anaes.)	hra
35645	(See para TN.8.45 of explanatory notes to this Category) Fee: \$318.70 Benefit: 75% = \$239.05 85% = \$270.90	
	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix (Anaes.)	
35646	(See para TN.8.45 of explanatory notes to this Category) Fee: \$203.65 Benefit: 75% = \$152.75 85% = \$173.15	
	CERVIX, large loop excision of transformation zone together with colposcopy for previously confir intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not bei service associated with a service to which item 35644 applies (Anaes.)	
35647	(See para TN.8.45 of explanatory notes to this Category) Fee: \$203.65 Benefit: 75% = \$152.75 85% = \$173.15	
	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes 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 bei service associated with a service to which item 35645 applies (Anaes.)	
35648	(See para TN.8.45 of explanatory notes to this Category) Fee: \$318.70 Benefit: 75% = \$239.05 85% = \$270.90	
	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.)	
35649	Fee: \$536.00 Benefit: 75% = \$402.00	
	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.)	
35653	Fee: \$674.70 Benefit: 75% = \$506.05	
	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which iter 35673 applies	n
35657	NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare	

T8. SUF	RGICAL OPERATIO	ONS	4. GYNAECOLOGICAL
		ayable for services not rendered in acc . Observe the explanatory note before	vordance with relevant Commonwealth and State submitting a claim. (Anaes.) (Assist.)
	(See para TN.8.46 c Fee: \$674.70	of explanatory notes to this Category) Benefit: 75% = \$506.05	
	UTERUS (at least at hysterectomy (A		l uterus), debulking of, prior to vaginal removal
35658	(See para TN.8.47 c Fee: \$416.05	f explanatory notes to this Category) Benefit: 75% = \$312.05	
	exposure of 1 or b		e retroperitoneal dissection, with or without vere endometriosis, pelvic inflammatory disease of the ovaries (Anaes.) (Assist.)
35661	Fee: \$871.30	Benefit: 75% = \$653.50	
	of uterine adnexae	e) for proven malignancy including exc	pelvic lymph glands (with or without excision cision of any 1 or more of parametrium, m and involving ureterolysis where performed
35664	Fee: \$1,452.20	Benefit: 75% = \$1089.15	
	for proven malign		n (with or without excision of uterine adnexae) ore of parametrium, paracolpos, upper vagina or where performed (Anaes.) (Assist.)
35667	Fee: \$1,234.25	Benefit: 75% = \$925.70	
		IY, abdominal, with radical excision of e (Anaes.) (Assist.)	f pelvic lymph glands, with or without removal
35670	Fee: \$1,016.30	Benefit: 75% = \$762.25	
		IY, VAGINAL (with or without uterin rian cyst, 1 or more, 1 or both sides (A	e curettage) with salpingectomy, oophorectomy naes.) (Assist.)
35673	Fee: \$757.80	Benefit: 75% = \$568.35	
	ULTRASOUND	GUIDED NEEDLING and injection of	f ectopic pregnancy
35674	(See para TN.4.11 c Fee: \$207.85	of explanatory notes to this Category) Benefit: 75% = \$155.90 85% = \$17	6.70
	ECTOPIC PREG	NANCY, removal of (Anaes.) (Assist.))
35677	Fee: \$536.00	Benefit: 75% = \$402.00	
	ECTOPIC PREG	NANCY, laparoscopic removal of (An	aes.) (Assist.)
35678	Fee: \$646.25	Benefit: 75% = \$484.70	
22070		JTERUS, plastic reconstruction for (A)	naes.) (Assist.)
25600		-	
35680	Fee: \$582.05	Benefit: 75% = \$436.55 85% = \$50	0.55 lependent procedure (Anaes.) (Assist.)
			rependent procedure (Anaes.) (Assist.)
35684	Fee: \$471.15	Benefit: 75% = \$353.40	
35688	STERILISATION	BY TRANSECTION OR RESECTION	ON OF FALLOPIAN TUBES, via abdominal or

T8. SUF	GICAL OPERATION	IS	4. GYNAECOLOGICAL
	vaginal routes or via	laparoscopy using diathermy or any o	other method
	benefits are not paya		ilisation procedures on minors. Medicare rdance with relevant Commonwealth and State ubmitting a claim. (Anaes.) (Assist.)
	(See para TN.8.46 of e Fee: \$397.25	Explanatory notes to this Category) Benefit: 75% = \$297.95	
	STERILISATION B with Caesarean secti		N TUBES, when performed in conjunction
	benefits are not paya		ilisation procedures on minors. Medicare rdance with relevant Commonwealth and State bmitting a claim. (Anaes.) (Assist.)
35691	(See para TN.8.46 of e Fee: \$158.70	xplanatory notes to this Category) Benefit: 75% = \$119.05	
		pingostomy, salpingolysis or tubal im nore procedures (Anaes.) (Assist.)	plantation into uterus), UNILATERAL or
35694	Fee: \$637.70	Benefit: 75% = \$478.30	
		L TUBOPLASTY (salpingostomy, salp BILATERAL, 1 or more procedures (A	pingolysis or tubal implantation into uterus), Anaes.) (Assist.)
35697	Fee: \$946.20	Benefit: 75% = \$709.65	
	FALLOPIAN TUBE (Assist.)	ES, unilateral microsurgical anastomos	sis of, using operating microscope (Anaes.)
35700	Fee: \$730.05	Benefit: 75% = \$547.55	
		N OF FALLOPIAN TUBES as a nonr vice to which another item in this Sub	repetitive procedure not being a service o-group applies (Anaes.)
35703	Fee: \$67.50	Benefit: 75% = \$50.65 85% = \$57.40)
	RUBIN TEST FOR	PATENCY OF FALLOPIAN TUBE	S (Anaes.)
35706	Fee: \$67.50	Benefit: 75% = \$50.65 85% = \$57.40)
	FALLOPIAN TUBE	ES, hydrotubation of, as a repetitive po	ostoperative procedure (Anaes.)
35709	Fee: \$43.50	Benefit: 75% = \$32.65 85% = \$37.00)
	FALLOPOSCOPY, (Assist.)	unilateral or bilateral, including hyste	proscopy and tubal catheterization (Anaes.)
35710	Fee: \$463.30	Benefit: 75% = \$347.50	
	OOPHORECTOMY	volving OOPHORECTOMY, SALPI , removal of OVARIAN, PARAOVA ocedure, other than a service associate	ARIAN, FIMBRIAL or BROAD LIGAMENT
	e i o i o i o o o o o o o o o o o o o o		5 5 7 7

T8. SUR	GICAL OPERATIONS	4. GYNAECOLOGICAL
	OOPHORECTOMY, removal of C	ORECTOMY, SALPINGECTOMY, SALPINGO- VARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT , unilateral or bilateral, other than a service associated with
35717	Fee: \$545.30 Benefit: 75%	= \$409.00
	RADICAL OR DEBULKING OP omentectomy (Anaes.) (Assist.)	ERATION for advanced gynaecological malignancy, with or without
35720	(See para TN.8.57 of explanatory note: Fee: \$674.50 Benefit: 75%	
	RETROPERITONEAL LYMPH N staging or restaging of gynaecolog	ODE BIOPSIES from above the level of the aortic bifurcation, for ical malignancy (Anaes.) (Assist.)
35723	Fee: \$483.10 Benefit: 75%	= \$362.35
	INFRACOLIC OMENTECTOMY gynaecological malignancy (Anaes	with multiple peritoneal biopsies for staging or restaging of .) (Assist.)
35726	Fee: \$483.10 Benefit: 75%	= \$362.35
	OVARIAN TRANSPOSITION ou malignancy (Anaes.)	t of the pelvis, in conjunction with radical hysterectomy for invasive
35729	Fee: \$217.80 Benefit: 75%	= \$163.35
		oth ovaries to preserve ovarian function, prior to gonadotoxic olume and dose of radiation have a high probability of causing
35730 S	Fee: \$217.80 Benefit: 75%	= \$163.35
	LAPAROSCOPICALLY ASSIST (Anaes.) (Assist.)	ED HYSTERECTOMY, including any associated laparoscopy
35750	Fee: \$784.60 Benefit: 75%	= \$588.45
	procedures: salpingectomy, oopho	ED HYSTERECTOMY with one or more of the following rectomy, excision of ovarian cyst or treatment of moderate acluding any associated laparoscopy (Anaes.) (Assist.)
35753	Fee: \$867.60 Benefit: 75%	= \$650.70
	or other pathology, from the ureter when performed with one or more	ED HYSTERECTOMY which requires dissection of endometriosis, , one or both sides, including any associated laparoscopy, including of the following procedures: salpingectomy, oophorectomy, excision cometriosis, not being a service to which item 35641 applies (Anaes.)
35754	Fee: \$1,091.90 Benefit: 75%	= \$818.95
		ED HYSTERECTOMY, when procedure is completed by open ated laparoscopy (Anaes.) (Assist.)
35756	Fee: \$784.60 Benefit: 75%	= \$588.45
35759		OPERATIVE HAEMORRHAGE following gynaecological surgery, a vaginal or abdominal and vaginal approach where no other

T8. SUF		ONS	4. GYNAECOLOGICAL
	procedure is perfo	ormed (Anaes.) (Assist.)	
	Fee: \$563.30	Benefit: 75% = \$422.50	
T8. SUF		ONS	5. UROLOGICAL
	Group T8. Surgio	cal Operations	
		Subgroup	5. Urological
		GEN	ERAL
	ADRENAL GLA	ND, excision of partial or total (A	naes.) (Assist.)
36500	Fee: \$924.70	Benefit: 75% = \$693.55	
	PELVIC LYMPH (Assist.)	IADENECTOMY, open or laparos	scopic, or both, unilateral or bilateral (Anaes.)
36502	Fee: \$683.90	Benefit: 75% = \$512.95	
	RENAL TRANSI	PLANT (not being a service to wh	ich item 36506 or 36509 applies) (Anaes.) (Assist.)
36503	Fee: \$1,391.15	Benefit: 75% = \$1043.40	
		PLANT, performed by vascular su ding aftercare (Anaes.) (Assist.)	rgeon and urologist operating together vascular
36506	Fee: \$924.70	Benefit: 75% = \$693.55	
		PLANT, performed by vascular su esical anastomosis including after	
36509	Fee: \$782.95	Benefit: 75% = \$587.25	
	NEPHRECTOM	Y, complete (Anaes.) (Assist.)	
36516	Fee: \$924.70	Benefit: 75% = \$693.55	
	NEPHRECTOM	Y, complete, complicated by previous	ous surgery on the same kidney (Anaes.) (Assist.)
36519	Fee: \$1,291.10	Benefit: 75% = \$968.35	
	NEPHRECTOM	Y, partial (Anaes.) (Assist.)	
36522	Fee: \$1,107.95	Benefit: 75% = \$831.00	
	NEPHRECTOM	Y, partial, complicated by previous	s surgery on the same kidney (Anaes.) (Assist.)
36525	Fee: \$1,574.45	Benefit: 75% = \$1180.85	
	tumour less than 1	Y, radical with en bloc dissection of locms in diameter, where perform opathological examination (Anaes	of lymph nodes, with or without adrenalectomy, for a ed if malignancy is clinically suspected but not .) (Assist.)
36526	(See para TN.8.48 c Fee: \$1,291.10	of explanatory notes to this Category) Benefit: 75% = \$968.35 85% =	= \$1209.40
36527	tumour 10cms or	more in diameter, or complicated	of lymph nodes, with or without adrenalectomy, for a by previous open or laparoscopic surgery on the ically suspected but not confirmed by

T8. SUF	RGICAL OPERATIO	DNS 5. UROLOGICAL
	histopathological	examination (Anaes.) (Assist.)
	(See para TN.8.48 o Fee: \$1,593.40	f explanatory notes to this Category) Benefit: $75\% = \$1195.05$ $85\% = \$1511.70$
		, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a 0 cms in diameter (Anaes.) (Assist.)
36528	Fee: \$1,291.10	Benefit: 75% = \$968.35
		, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a more in diameter, or complicated by previous open or laparoscopic surgery on the es.) (Assist.)
36529	Fee: \$1,593.40	Benefit: 75% = \$1195.05
		RECTOMY, complete, including associated bladder repair and any associated lures (Anaes.) (Assist.)
36531	Fee: \$1,157.85	Benefit: 75% = \$868.40
		ERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including repair and any associated endoscopic procedures (Anaes.) (Assist.)
36532	Fee: \$1,661.85	Benefit: 75% = \$1246.40
	associated bladder	ERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including repair and any associated endoscopic procedures, complicated by previous open or ory on the same kidney or ureter (Anaes.) (Assist.)
36533	Fee: \$1,964.15	Benefit: 75% = \$1473.15
		INEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open g a service to which another item in this Sub-group applies (Anaes.) (Assist.)
36537	Fee: \$691.40	Benefit: 75% = \$518.55
	NEPHROLITHO stones (Anaes.) (A	COMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 ssist.)
36540	Fee: \$1,107.95	Benefit: 75% = \$831.00 85% = \$1026.25
	stones, including 1	COMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more or more of the following: nephrostomy, pyelostomy, pedicle control with or without uphy or pyeloplasty (Anaes.) (Assist.)
36543	Fee: \$1,291.10	Benefit: 75% = \$968.35 85% = \$1209.40
		EAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care ng pretreatment consultation, unilateral (Anaes.)
36546	Fee: \$691.40	Benefit: 75% = \$518.55 85% = \$609.70
	URETEROLITHO	DTOMY (Anaes.) (Assist.)
36549	Fee: \$833.10	Benefit: 75% = \$624.85
		f or pyelostomy, open, as an independent procedure (Anaes.) (Assist.)
26550	Fee: \$741.50	Benefit: 75% = \$556.15
36552		R CYSTS, excision or unroofing of (Anaes.) (Assist.)
36558		(CTSTS, excision of uncoming of (rundes.) (ressist.)

T8. SUF	RGICAL OPERAT	ONS 5. UROLOGICAL
	Fee: \$649.80	Benefit: 75% = \$487.35 85% = \$568.10
	RENAL BIOPSY	(closed) (Anaes.)
36561	Fee: \$172.50	Benefit: 75% = \$129.40 85% = \$146.65
		, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy ssisted techniques (Anaes.) (Assist.)
36564	Fee: \$924.70	Benefit: 75% = \$693.55
		in a kidney that is congenitally abnormal in addition to the presence of PUJ a solitary kidney, by open exposure (Anaes.) (Assist.)
36567	Fee: \$1,016.30	Benefit: 75% = \$762.25
	PYELOPLASTY (Assist.)	, complicated by previous surgery on the same kidney, by open exposure (Anaes.)
36570	Fee: \$1,291.10	Benefit: 75% = \$968.35
	DIVIDED URET	ER, repair of (Anaes.) (Assist.)
36573	Fee: \$924.70	Benefit: 75% = \$693.55
		are and exploration of, including repair or nephrectomy, for trauma, not being a service ny other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.)
36576	Fee: \$1,157.85	Benefit: 75% = \$868.40
		MY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a d with a service to which item 37000 applies (Anaes.) (Assist.)
36579	Fee: \$741.50	Benefit: 75% = \$556.15
	URETER, transp	lantation of, into skin (Anaes.) (Assist.)
36585	Fee: \$741.50	Benefit: 75% = \$556.15
	URETER, reimp	antation into bladder (Anaes.) (Assist.)
36588	Fee: \$924.70	Benefit: 75% = \$693.55
20200		antation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.)
36591	Fee: \$1,107.95	Benefit: 75% = \$831.00
50571		lantation of, into intestine (Anaes.) (Assist.)
36594	Fee: \$924.70	Benefit: 75% = \$693.55
30394		lantation of, into another ureter (Anaes.) (Assist.)
	-	
36597	Fee: \$924.70	Benefit: 75% = \$693.55
	UKETER, transp	lantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.)
36600	Fee: \$1,107.95	Benefit: 75% = \$831.00 85% = \$1026.25
	URETERS, trans	plantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.)
36603	Fee: \$1,291.10	Benefit: 75% = \$968.35
36604	URETERIC STE	NT, passage of through percutaneous nephrostomy tube, using interventional imaging

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICAL
	techniques (Anae	s.)
	Fee: \$267.65	Benefit: 75% = \$200.75 85% = \$227.55
	URETERIC STE	NT, insertion of, with removal of calculus from:
	(a) the pelvical	yceal system; or
	(b) ureter; or	
	(c) the pelvical	yceal system and ureter;
	through a nephros	stomy tube using interventional imaging techniques (Anaes.)
36605	Fee: \$690.70	Benefit: 75% = \$518.05
		RINARY RESERVOIR, continent, formation of, including formation of nonreturn natation of ureters (1 or both) into reservoir (Anaes.) (Assist.)
36606	Fee: \$2,315.80	Benefit: 75% = \$1736.85
	URETERIC STE	NT insertion of, with baloon dilatation of:
	(a) the pelvical	yceal system; or
	(b) ureter; or	
	(c) the pelvical	yceal system and ureter;
	through a nephros	stomy tube using interventional imaging techniques (Anaes.)
36607	Fee: \$690.70	Benefit: 75% = \$518.05
		NT, exchange of, percutaneously through either the ileal conduit or bladder, using aging techniques, not being a service associated with a service to which items 36811 to uses.)
36608	Fee: \$267.65	Benefit: 75% = \$200.75
	INTESTINAL UI	RINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.)
36609	Fee: \$741.50	Benefit: 75% = \$556.15
	URETER, explore	ation of, with or without drainage of, as an independent procedure (Anaes.) (Assist.)
36612	Fee: \$649.80	Benefit: 75% = \$487.35
	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 fibrosi or similar condition (Anaes.) (Assist.)	
36615	Fee: \$741.50	Benefit: 75% = \$556.15
	REDUCTION U	RETEROPLASTY (Anaes.) (Assist.)
36618	Fee: \$649.80	Benefit: 75% = \$487.35
	CLOSURE OF C	UTANEOUS URETEROSTOMY (Anaes.) (Assist.)
36621	Fee: \$464.50	Benefit: 75% = \$348.40

T8. SUF	GICAL OPERAT	IONS	5. UROLOGICAL
	NEPHROSTOM	IY, percutaneous, using interventional im	aging techniques (Anaes.) (Assist.)
36624	Fee: \$558.10	Benefit: 75% = \$418.60 85% = \$476	i.40
		Y, percutaneous, with or without any 1 or eing a service to which item 36639, 3664	
36627	Fee: \$691.40	Benefit: 75% = \$518.55	
	substantial portion	Y, BEING A SERVICE TO WHICH ITE on of the procedure has been performed, I UE TO BLEEDING (Anaes.) (Assist.)	EM 36627 APPLIES, WHERE, after a IT IS NECESSARY TO DISCONTINUE THE
36630	Fee: \$341.50	Benefit: 75% = \$256.15	
	ureter and includ		r more of; renal pelvis, calyx or calyces or not being a service associated with a service to s (Anaes.) (Assist.)
36633	Fee: \$741.50	Benefit: 75% = \$556.15 85% = \$659	.80
	ureter and includ		r more of; renal pelvis, calyx or calyces or being a service associated with a service to s (Anaes.) (Assist.)
36636	Fee: \$399.90	Benefit: 75% = \$299.95	
			traction of 1 or 2 stones using ultrasound or ee to which item 36645 or 36648 applies)
36639	Fee: \$833.10	Benefit: 75% = \$624.85	
	substantial portion	Y, BEING A SERVICE TO WHICH ITE on of the procedure has been performed, I UE TO BLEEDING (Anaes.) (Assist.)	EM 36639 APPLIES, WHERE, after a IT IS NECESSARY TO DISCONTINUE THE
36642	Fee: \$416.45	Benefit: 75% = \$312.35	
		Y, percutaneous, with removal or destruc r 3 or more stones (Anaes.) (Assist.)	tion of a stone greater than 3 cm in any
36645	Fee: \$1,066.30	Benefit: 75% = \$799.75	
		s been performed, IT IS NECESSARY T	pplies, WHERE, after a substantial portion of O DISCONTINUE THE OPERATION
36648	Fee: \$949.60	Benefit: 75% = \$712.20	
	NEPHROSTOM	Y DRAINAGE TUBE, exchange of - bu	tt not including imaging (Anaes.) (Assist.)
36649	Fee: \$267.65	Benefit: 75% = \$200.75 85% = \$227	.55
		IY TUBE, removal of, if the ureter has be n place, using interventional imaging tech	een stented with a double J ureteric stent and hniques (Anaes.)
36650	Fee: \$149.70	Benefit: 75% = \$112.30	
36652			th or without any one or more of, cystoscopy, e associated with a service to which item

T8. SUF	RGICAL OPERATI	ONS	5. UROLOGICAL	
	36803, 36812 or 3	36824 applies (Anaes.) (Assist.)		
	Fee: \$649.80	Benefit: 75% = \$487.35		
	1 or more of extra pelvis or calyces,	retrograde, of one collecting system, being a ser action of stone from the renal pelvis or calyces, not being a service associated with a service to ned in the same collecting system (Anaes.) (Ass	or biopsy or diathermy of the renal which item 36656 applies to a	
36654	Fee: \$833.10	Benefit: 75% = \$624.85		
	extraction of 2 or electrohydraulic of fragments, not be	retrograde, of one collecting system, being a set more stones in the renal pelvis or calyces or de or kinetic lithotripsy, or laser in the renal pelvis ing a service associated with a service to which same collecting system (Anaes.) (Assist.)	struction of stone with ultrasound, or calyces, with or without extraction of	
36656	Fee: \$1,066.30	Benefit: 75% = \$799.75		
		OPERATIONS ON BLADD	ER	
	Both:			
	(a) percutaneous placement of sacral nerve lead or leads using fluoroscopic guidance, or open placement of sacral nerve lead or leads; and			
	(b) intra-operative	(b) intra-operative test stimulation, to manage:		
	(i) detrusor treatment; o	over-activity that has been refractory to at least r	12 months conservative non-surgical	
	(ii) non-obs non-surgica	tructive urinary retention that has been refractor l treatment	ry to at least 12 months conservative	
	(Anaes.)			
36663	Fee: \$660.95	Benefit: 75% = \$495.75 85% = \$579.25		
	Both:			
	(a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and			
	(b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of:			
	(i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or			
		(ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment		
	—other than	n a service to which item 36663 applies (Anaes.)	
36664	Fee: \$593.55	Benefit: 75% = \$445.20 85% = \$511.85		
		trode or electrodes, management and adjustmen anage detrusor overactivity or non obstructive u		
1	Fee: \$125.40	Benefit: 75% = \$94.05 85% = \$106.60		

T8. SUF	GICAL OPERATIONS	5. UROLOGICAL
	Pulse generator, subcutaneous placement of, and placement and c sacral nerve electrode or electrodes, for the management of:	connection of extension wire or wires to
	(a) detrusor over-activity that has been refractory to at least 12 metreatment; or	onths conservative non-surgical
	(b) non-obstructive urinary retention that has been refractory to a non-surgical treatment (Anaes.)	t least 12 months conservative
36666	Fee: \$334.00 Benefit: 75% = \$250.50 85% = \$283.90	
	Sacral nerve lead or leads, removal of, if the lead was inserted to	manage:
	(a) detrusor over-activity that has been refractory to at least 12 metreatment; or	onths conservative non-surgical
	(b) non-obstructive urinary retention that has been refractory to a non-surgical treatment	t least 12 months conservative
	(Anaes.)	
36667	Fee: \$156.30 Benefit: 75% = \$117.25 85% = \$132.90	
	Pulse generator, removal of, if the pulse generator was inserted to) manage:
	(a) detrusor over-activity that has been refractory to at least 12 m treatment; or	onths conservative non-surgical
	(b) non-obstructive urinary retention that has been refractory to a non-surgical treatment	t least 12 months conservative
	(Anaes.)	
36668	Fee: \$156.30 Benefit: 75% = \$117.25 85% = \$132.90	
	BLADDER, catheterisation of, where no other procedure is perfo	rmed (Anaes.)
36800	Fee: \$27.60 Benefit: 75% = \$20.70 85% = \$23.50	
	URETEROSCOPY, of one ureter, with or without any one or mo or ureteric dilatation, not being a service associated with a service 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Au	e to which item 36652, 36654,
36803	(See para TN.8.51 of explanatory notes to this Category) Fee: \$466.35 Benefit: 75% = \$349.80 85% = \$396.40	
	URETEROSCOPY, of one ureter, with or without any one or mo or ureteric dilatation, plus one or more of extraction of stone from the ureter, not being a service associated with a service to which service associated with a service to which item 36809, 36824, 36 performed on the same ureter (Anaes.) (Assist.)	n the ureter, or biopsy or diathermy of item 36803 or 36812 applies, or a
36806	Fee: \$649.80 Benefit: 75% = \$487.35	
36809	URETEROSCOPY, of one ureter, with or without any one or mo or ureteric dilatation, PLUS destruction of stone in the ureter with lithotripsy, or laser, with or without extraction of fragments, not b	n ultrasound, electrohydraulic or kinetic

T8. SUF	RGICAL OPERATI	ONS	5. UROLOGICAL
			service associated with a service to which item 36806, re performed on the same ureter (Anaes.) (Assist.)
	Fee: \$833.10	Benefit: 75% = \$624.85	
	CYSTOSCOPY	with insertion of urethral pr	rosthesis (Anaes.)
36811	Fee: \$323.40	Benefit: 75% = \$242.55	85% = \$274.90
		ological endoscopic proced	without urethral dilatation, not being a service associated lure on the lower urinary tract except a service to which item
36812	Fee: \$166.70	Benefit: 75% = \$125.05	85% = \$141.70
			py, for the treatment of penile warts or uretheral warts, not which item 30189 applies (Anaes.)
36815	(See para TN.8.9 of Fee: \$237.90	f explanatory notes to this Cat Benefit: 75% = \$178.45	
		eral, not being a service ass	n including fluoroscopic imaging of the upper urinary tract, sociated with a service to which item 36824 or 36830 applies
36818	Fee: \$276.60	Benefit: 75% = \$207.45	85% = \$235.15
		lvis, unilateral, not being a	dilatation, insertion of ureteric stent, or brush biopsy of service associated with a service to which item 36824 or
36821	Fee: \$323.20	Benefit: 75% = \$242.40	85% = \$274.75
		with ureteric catheterisation h item 36818 or 36821 app	n, unilateral or bilateral, not being a service associated with lies (Anaes.)
36824	Fee: \$213.15	Benefit: 75% = \$159.90	85% = \$181.20
	removal or replac		f pelviureteric junction or ureteric stricture, including t being a service associated with a service to which item es (Anaes.) (Assist.)
36825	Fee: \$581.30	Benefit: 75% = \$436.00	
	CYSTOSCOPY,	with controlled hydrodilata	ation of the bladder (Anaes.)
36827	Fee: \$229.85	Benefit: 75% = \$172.40	85% = \$195.40
	CYSTOSCOPY,	with ureteric meatotomy (A	Anaes.)
36830	Fee: \$203.25	Benefit: 75% = \$152.45	
			ent or other foreign body (Anaes.) (Assist.)
36833	Fee: \$276.60	Benefit: 75% = \$207.45	85% = \$235.15
		1 1	t being a service associated with a service to which item , 37203, 37206 or 37215 applies (Anaes.)
36836	Fee: \$229.85	Benefit: 75% = \$172.40	85% = \$195.40
36840	CYSTOSCOPY,	with resection, diathermy of	or visual laser destruction of bladder tumour or other lesion

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL
	of the bladder, n	ot being a service to which item 36845 applies (Anaes.)
	Fee: \$323.20	Benefit: 75% = \$242.40 85% = \$274.75
	or bladder and n	, with lavage of blood clots from bladder including any associated diathermy of prostate ot being a service associated with a service to which item 36812, 36827 to 36863, 37203 (Anaes.) (Assist.)
36842	Fee: \$325.20	Benefit: 75% = \$243.90
		, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 bladder or solitary tumour greater than 2cm in diameter (Anaes.)
36845	Fee: \$691.40	Benefit: 75% = \$518.55 85% = \$609.70
	CYSTOSCOPY	, with resection of ureterocele (Anaes.)
36848	Fee: \$229.85	Benefit: 75% = \$172.40
		h injection into bladder wall, other than a service associated with a service to which item applies (H) (Anaes.)
36851	(See para TN.8.2 o Fee: \$229.85	of explanatory notes to this Category) Benefit: 75% = \$172.40
	CYSTOSCOPY (Anaes.)	, with endoscopic incision or resection of external sphincter, bladder neck or both
36854	Fee: \$466.35	Benefit: 75% = \$349.80
	ENDOSCOPIC	MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.)
36857	Fee: \$366.45	Benefit: 75% = \$274.85
	ENDOSCOPIC	EXAMINATION of intestinal conduit or reservoir (Anaes.)
36860	Fee: \$166.70	Benefit: 75% = \$125.05 85% = \$141.70
	LITHOLAPAX	Y, with or without cystoscopy (Anaes.) (Assist.)
36863	Fee: \$466.35	Benefit: 75% = \$349.80
	BLADDER, par	tial excision of (Anaes.) (Assist.)
37000	Fee: \$741.50	Benefit: 75% = \$556.15
	BLADDER, rep	air of rupture (Anaes.) (Assist.)
37004	Fee: \$649.80	Benefit: 75% = \$487.35
	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.)	
37008	Fee: \$416.45	Benefit: 75% = \$312.35 85% = \$354.00
	SUPRAPUBIC S 37200 to 37221	STAB CYSTOTOMY, not being a service associated with a service to which items apply (Anaes.)
37011	Fee: \$93.35	Benefit: 75% = \$70.05 85% = \$79.35
	BLADDER, tota	ll excision of (Anaes.) (Assist.)
37014	Fee: \$1,066.30	Benefit: 75% = \$799.75

T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL
	BLADDER DIV	/ERTICULUM, excision or obliteration of (Anaes.) (Assist.)
37020	Fee: \$741.50	Benefit: 75% = \$556.15	
	VESICAL FIST	ULA, cutaneous, operation for (Anaes.)	
37023	Fee: \$416.45	Benefit: 75% = \$312.35	
	CUTANEOUS	VESICOSTOMY, establishment of (Anaes.)) (Assist.)
37026	Fee: \$416.45	Benefit: 75% = \$312.35	
	VESICOVAGIN	NAL FISTULA, closure of, by abdominal ap	pproach (Anaes.) (Assist.)
37029	Fee: \$924.70	Benefit: 75% = \$693.55	
	VESICOINTES	TINAL FISTULA, closure of, excluding bo	wel resection (Anaes.) (Assist.)
37038	Fee: \$691.75	Benefit: 75% = \$518.85	
		ncontinence, sling procedure for, using a non mesh, other than a service associated with a Anaes.) (Assist.)	
37040	Fee: \$911.30	Benefit: 75% = \$683.50	
	BLADDER ASI	PIRATION by needle	
37041	Fee: \$46.60	Benefit: 75% = \$34.95 85% = \$39.65	
	harvesting of sli	RESS INCONTINENCE, sling procedure for ng, with or without mesh, not being a servic applies (Anaes.) (Assist.)	
37042	Fee: \$911.30	Benefit: 75% = \$683.50	
		RESS INCONTINENCE, Stamey or similar ot being a service associated with a service t .)	
37043	Fee: \$674.50	Benefit: 75% = \$505.90	
		RESS INCONTINENCE, suprapubic proced ot being a service associated with a service t .)	
37044	Fee: \$691.75	Benefit: 75% = \$518.85	
	CONTINENT CATHETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.) (Assist.)		S (eg. Mitrofanoff), formation of (Anaes.)
37045	Fee: \$1,428.75	Benefit: 75% = \$1071.60	
	BLADDER EN	LARGEMENT using intestine (Anaes.) (Ass	sist.)
27047	Fee: \$1,666.05	Benefit: 75% = \$1249.55	
37047		STROPHY CLOSURE, not involving sphine	cter reconstruction (Anaes) (Assist)
37047	BLADDER EX		
37047	BLADDER EX: Fee: \$741.50	Benefit: 75% = \$556.15	
	Fee: \$741.50		

T8. SUF	GICAL OPERATIONS 5. UROLOGICAI
	OPERATIONS ON PROSTATE
	PROSTATECTOMY, open (Anaes.) (Assist.)
37200	Fee: \$1,016.30 Benefit: 75% = \$762.25
	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with 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.)
37201	(See para TN.8.53 of explanatory notes to this Category) Fee: \$828.85 Benefit: 75% = \$621.65
	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.)
37202	(See para TN.8.53 of explanatory notes to this Category)Fee: $$416.05$ Benefit: $75\% = 312.05 $85\% = 353.65
	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.)
37203	Fee: \$1,042.15 Benefit: 75% = \$781.65
	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.)
37206	Fee: \$558.10 Benefit: 75% = \$418.60
	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.)
37207	Fee: \$866.45 Benefit: 75% = \$649.85
	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.)
37208	Fee: \$416.05 Benefit: 75% = \$312.05
	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.)
37209	Fee: \$1,291.10 Benefit: 75% = \$968.35
	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.)
37210	

T8. SUR	GICAL OPERATIONS		5. UROLOGICAL	
	Fee: \$1,593.40	Benefit: 75% = \$1195.05		
	bladder and bladd	MY, radical, involving total excision of the prostern eck reconstruction, <i>with pelvic lymphadenect</i> which item 35551, 36502 or 37375 applies (Anaerov)	tomy, not being a service associated	
37211	Fee: \$1,935.20	Benefit: 75% = \$1451.40		
	PROSTATE, oper	n perineal biopsy or open drainage of abscess (An	naes.) (Assist.)	
37212	Fee: \$276.60	Benefit: 75% = \$207.45		
	PROSTATE, biop	sy of, endoscopic, with or without cystoscopy (A	Anaes.) (Assist.)	
37215	Fee: \$416.45	Benefit: 75% = \$312.35 85% = \$354.00		
	Prostate, implanta (Anaes.)	tion of radio-opaque fiducial markers into the pro	ostate gland or prostate surgical bed	
37217	(See para TN.8.2, T Fee: \$138.30	N.8.54 of explanatory notes to this Category) Benefit: 75% = \$103.75 85% = \$117.60		
	PROSTATE, need	lle biopsy of, or injection into, excluding for inse	ertion of radiopaque markers (Anaes.)	
37218	Fee: \$138.30	Benefit: 75% = \$103.75 85% = \$117.60		
		lle biopsy of, using prostatic ultrasound techniqu a service associated with a service to which item	U	
37219	Fee: \$280.85	Benefit: 75% = \$210.65 85% = \$238.75		
	guidance, for loca palpable or visible than or equal to 7 diagnosis. The pr	bactive seed implantation of, urological component lised prostatic malignancy at clinical stages T1 (description) or T2 (tumour confined within prosent and a prostate specific antigen (PSA) of less than be performed by a urologist at an a st, and be associated with a service to which item	clinically inapparent tumour not state), with a Gleason score of less n or equal to 10ng/ml at the time of pproved site in association with a	
37220	(See para TN.8.55 o Fee: \$1,044.20	f explanatory notes to this Category) Benefit: 75% = \$783.15		
		SCESS, endoscopic drainage of (Anaes.) (Assist.)	
37221	Fee: \$466.35	Benefit: 75% = \$349.80		
	PROSTATIC CO	L, insertion of, under ultrasound control (Anaes.)	
37223	Fee: \$206.25	Benefit: 75% = \$154.70		
	PROSTATE, diat	nermy or visual laser destruction of lesion of, not em 37201, 37202, 37203, 37206, 37207, 37208	•	
37224	Fee: \$323.20	Benefit: 75% = \$242.40 85% = \$274.75		
	guidance includin	sperineal insertion of catheters into, for high dose g any associated cystoscopy. The procedure must radiation oncologist, and be associated with a se	t be performed at an approved site in	
37227	(See para TN.8.56 o Fee: \$565.85	f explanatory notes to this Category) Benefit: 75% = \$424.40 85% = \$484.15		

T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL
	with or without		motherapy of, with or without cystoscopy and which item 36854, 37203, 37206, 37207, 37208,
37230	Fee: \$1,042.15	Benefit: 75% = \$781.65 85% = \$96	50.45
	with or without applies, continua	rethroscopy and including services to	motherapy of, with or without cystoscopy and which item 36854, 37303, 37321 or 37324 e described by item 37201, 37203, 37207, 37230 es.)
37233	Fee: \$558.10	Benefit: 75% = \$418.60 85% = \$47	76.40
	contact fibre, wi benign prostatic	h or without tissue morcellation, cystos	Holmium: YAG laser and an end-firing, non- scopy or urethroscopy, for the treatment of sociated with a service to which item 36854, 321, or 37324 applies. (Anaes.)
37245	Fee: \$1,262.15	Benefit: 75% = \$946.65	
		OPERATIONS ON URETHRA	, PENIS OR SCROTUM
	URETHRAL SC	UNDS, passage of, as an independent	procedure (Anaes.)
37300	Fee: \$46.60	Benefit: 75% = \$34.95 85% = \$39.	65
	URETHRAL ST	RICTURE, dilatation of (Anaes.)	
37303	Fee: \$74.05	Benefit: 75% = \$55.55 85% = \$62.	95
	URETHRA, rep	air of rupture of distal section (Anaes.)	
37306	Fee: \$649.80	Benefit: 75% = \$487.35	
01000		air of rupture of prostatic or membrano	us segment (Anaes.) (Assist.)
37309	Fee: \$924.70	Benefit: 75% = \$693.55	
57507		PY, as an independent procedure (Anat	es.)
27215			
37315	Fee: \$138.30	Benefit: $75\% = 103.75 $85\% = 11	hermy, visual laser destruction of stone or
		gn body or stone (Anaes.) (Assist.)	neriny, visual laser destruction of stone of
37318	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$23	35.15
		EATOTOMY, EXTERNAL (Anaes.)	
37321	Fee: \$93.35	Benefit: 75% = \$70.05 85% = \$79.	35
57521	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.)		
27224			
37324	Fee: \$229.85	Benefit: 75% = \$172.40 IY, optical, for urethral stricture (Anaes	a) (Assist)
		-	., (2 20010)
37327	Fee: \$323.20	Benefit: 75% = \$242.40	S. (A.) (A.) (A.)
	UKETHRECTO	MY, partial or complete, for removal or	t tumour (Anaes.) (Assist.)
37330	Fee: \$649.80	Benefit: 75% = \$487.35	

T8. SUR	GICAL OPERATI	ONS 5. UROLOGI	CAL
	URETHROVAG	NAL FISTULA, closure of (Anaes.) (Assist.)	
37333	Fee: \$558.10	Benefit: 75% = \$418.60	
	URETHRORECT	AL FISTULA, closure of (Anaes.) (Assist.)	
37336	Fee: \$741.50	Benefit: 75% = \$556.15	
	following previou	male sling system, division or removal of, for urethral obstruction or erosion, s surgery for urinary incontinence, other than a service associated with a service to or 37341 applies (Anaes.) (Assist.)	C
37338	Fee: \$911.30	Benefit: 75% = \$683.50	
		nsurethral injection of materials for the treatment of urinary incontinence, includin rethroscopy, other than a service associated with a service to which item 18375 or naes.)	ıg
37339	(See para TN.8.2 of Fee: \$239.85	explanatory notes to this Category) Benefit: 75% = \$179.90 85% = \$203.90	
	surgery for urinar	NG, division or removal of, for urethral obstruction or erosion, following previous y incontinence, vaginal approach, not being a service associated with a service to er 37341 applies (Anaes.) (Assist.)	3
37340	Fee: \$425.00	Benefit: 75% = \$318.75	
	surgery for urinar	NG, division or removal of, for urethral obstruction or erosion, following previous y incontinence, suprapubic or combined suprapubic/vaginal approach, not being a with a service to which item number 37340 applies (Anaes.) (Assist.)	
37341	Fee: \$911.30	Benefit: 75% = \$683.50	
	URETHROPLAS	TY single stage operation (Anaes.) (Assist.)	
37342	Fee: \$833.10	Benefit: 75% = \$624.85	
	below the symphy	TY, single stage operation, transpubic approach via separate incisions above and vsis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with g of the urethra around the crura (Anaes.) (Assist.)	ı or
37343	Fee: \$1,391.15	Benefit: 75% = \$1043.40	
	URETHROPLAS	TY 2 stage operation first stage (Anaes.) (Assist.)	
37345	Fee: \$691.40	Benefit: 75% = \$518.55	
	URETHROPLAS	TY 2 stage operation second stage (Anaes.) (Assist.)	
37348	Fee: \$691.40	Benefit: 75% = \$518.55	
	URETHROPLAS	TY, not being a service to which another item in this Group applies (Anaes.) (Assi	ist.)
37351	Fee: \$276.60	Benefit: 75% = \$207.45	
	HYPOSPADIAS	meatotomy and hemicircumcision (Anaes.) (Assist.)	
37354	Fee: \$323.20	Benefit: 75% = \$242.40	
	URETHRA, exci	sion of prolapse of (Anaes.)	
37369	Fee: \$186.60	Benefit: 75% = \$139.95	

T8. SUF	RGICAL OPERATIO	DNS 5. UROLOGICAL
	URETHRAL DIV	ERTICULUM, excision of (Anaes.) (Assist.)
37372	Fee: \$466.35	Benefit: 75% = \$349.80
	URETHRAL SPH (Anaes.) (Assist.)	INCTER, reconstruction by bladder tubularisation technique or similar procedure
37375	Fee: \$1,157.85	Benefit: 75% = \$868.40
	ARTIFICIAL URI	NARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.)
37381	Fee: \$741.50	Benefit: 75% = \$556.15
	ARTIFICIAL URI	NARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.)
37384	Fee: \$1,157.85	Benefit: 75% = \$868.40
	ARTIFICIAL URI (Assist.)	NARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.)
37387	Fee: \$323.20	Benefit: 75% = \$242.40
	ARTIFICIAL URI (Assist.)	NARY SPHINCTER, revision or removal of, with or without replacement (Anaes.)
37390	Fee: \$924.70	Benefit: 75% = \$693.55
	PRIAPISM, decom without lavage (An	npression by glanular stab cavernosospongiosum shunt or penile aspiration with or naes.)
37393	Fee: \$229.85	Benefit: 75% = \$172.40 85% = \$195.40
	PRIAPISM, shunt	operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)
37396	Fee: \$741.50	Benefit: 75% = \$556.15
	PENIS, partial amp	putation of (Anaes.) (Assist.)
37402	Fee: \$466.35	Benefit: 75% = \$349.80
	PENIS, complete of	or radical amputation of (Anaes.) (Assist.)
37405	Fee: \$924.70	Benefit: 75% = \$693.55
	PENIS, repair of la	aceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)
37408	Fee: \$466.35	Benefit: 75% = \$349.80
	PENIS, repair of a	vulsion (Anaes.) (Assist.)
37411	Fee: \$924.70	Benefit: 75% = \$693.55 85% = \$843.00
	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 3 consecutive months	
37415	Fee: \$46.60	Benefit: 75% = \$34.95 85% = \$39.65
	PENIS, correction grafting (Anaes.) (of chordee, with or without excision of fibrous plaque or plaques and with or without Assist.)
37417	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

T8. SUF	RGICAL OPERAT	TONS 5. UROLOGICAL
	grafting, involvi	ng mobilization of the urethra (Anaes.) (Assist.)
	Fee: \$741.50	Benefit: 75% = \$556.15 85% = \$659.80
		to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes.)
37420	Fee: \$366.45	Benefit: 75% = \$274.85
	PENIS, lengther	ning by translocation of corpora (Anaes.) (Assist.)
37423	Fee: \$924.70	Benefit: 75% = \$693.55
	PENIS, artificia	l erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.)
37426	Fee: \$974.55	Benefit: 75% = \$730.95
	PENIS, artificia	l erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.)
37429	Fee: \$323.20	Benefit: 75% = \$242.40
	PENIS, artificia replacement (Ar	l erection device, complete or partial revision or removal of components, with or without naes.) (Assist.)
37432	Fee: \$924.70	Benefit: 75% = \$693.55
	PENIS, frenulop	plasty as an independent procedure (Anaes.)
37435	Fee: \$93.35	Benefit: 75% = \$70.05 85% = \$79.35
	SCROTUM, par	tial excision of (Anaes.) (Assist.)
37438	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15
	URETEROLITH ureter (Anaes.) (HOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same (Assist.)
37444	Fee: \$999.65	Benefit: 75% = \$749.75 85% = \$917.95
		OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
	SPERMATOCE	LE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.)
37601	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15
		N OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, eing a service associated with sperm harvesting for IVF (Anaes.)
37604	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15
		sperm retrieval, unilateral, from either the testis or the epididymis, for the purposes mic sperm injection, for male factor infertility, excluding a service to which item 13218)
37605	(See para TN.8.58 Fee: \$373.45	3, TN.1.5 of explanatory notes to this Category) Benefit: 75% = \$280.10 85% = \$317.45
	biopsy, for the p	berm retrieval, unilateral, including the exploration of scrotal contents, with our without purposes of intracytoplasmic sperm injection, for male factor infertility, performed in a ing a service to which item 13218 or 37604 applies. (Anaes.)
37606	(See para TN.1.5, Fee: \$554.55	TN.8.59 of explanatory notes to this Category) Benefit: $75\% = 415.95 $85\% = 472.85

	RGICAL OPERATI	IONS	5. UROLOGICAL
		NEAL LYMPH NODE DISSECTION, unilateral, not being a service associate tem 36528 applies (Anaes.) (Assist.)	
37607	Fee: \$924.70	Benefit: 75% = \$693.55	
	service to which	NEAL LYMPH NODE DISSECTION, unilateral, item 36528 applies, following previous similar retr radiation or chemotherapy (Anaes.) (Assist.)	
37610	Fee: \$1,391.15	Benefit: 75% = \$1043.40	
	EPIDIDYMECT	OMY (Anaes.)	
37613	Fee: \$276.60	Benefit: 75% = \$207.45 85% = \$235.15	
		OMY or VASOEPIDIDYMOSTOMY, unilateral, use ssociated with sperm harvesting for IVF (Anaes.) (
37616	Fee: \$691.40	Benefit: 75% = \$518.55	
		OMY or VASOEPIDIDYMOSTOMY, unilateral, 1 ; for IVF (Anaes.) (Assist.)	not being a service associated with
37619	Fee: \$276.60 Extended Medic	Benefit: 75% = \$207.45 85% = \$235.15 care Safety Net Cap: \$221.30	
		gal requirements apply in relation to sterilisation p payable for services not rendered in accordance wi	
	benefits are not p		th relevant Commonwealth and State
37623	benefits are not p and Territory law	payable for services not rendered in accordance wi	th relevant Commonwealth and State
37623	benefits are not p and Territory law (See para TN.8.46	bayable for services not rendered in accordance wi w. Observe the explanatory note before submitting of explanatory notes to this Category)	th relevant Commonwealth and State a claim. (Anaes.)
37623	benefits are not p and Territory law (See para TN.8.46) Fee: \$229.85	bayable for services not rendered in accordance wi v. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40	th relevant Commonwealth and State a claim. (Anaes.) GERY
37623	benefits are not p and Territory law (See para TN.8.46) Fee: \$229.85	bayable for services not rendered in accordance wi v. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40 PAEDIATRIC GENITURINARY SUR	th relevant Commonwealth and State a claim. (Anaes.) GERY
	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25	bayable for services not rendered in accordance wi v. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.)
37800	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25 PATENT URAC	bayable for services not rendered in accordance wi w. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o Benefit: 75% = \$390.95 CHUS, excision of, when performed on a person und	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.)
	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25 PATENT URAC Fee: \$677.65 UNDESCENDE	bayable for services not rendered in accordance wi w. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o Benefit: 75% = \$390.95	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.) der 10 years of age (Anaes.) (Assist.)
37800 37801	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25 PATENT URAC Fee: \$677.65 UNDESCENDE	bayable for services not rendered in accordance wi v. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o Benefit: 75% = \$390.95 CHUS, excision of, when performed on a person und Benefit: 75% = \$508.25 D TESTIS, orchidopexy for, not being a service to	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.) der 10 years of age (Anaes.) (Assist.)
37800 37801	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25 PATENT URAC Fee: \$677.65 UNDESCENDED person 10 years of Fee: \$521.25 UNDESCENDED	bayable for services not rendered in accordance wi w. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: $75\% = \$172.40 \ 85\% = \195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o Benefit: $75\% = \$390.95$ CHUS, excision of, when performed on a person und Benefit: $75\% = \$508.25$ D TESTIS, orchidopexy for, not being a service to of age or over. (Anaes.) (Assist.)	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.) der 10 years of age (Anaes.) (Assist.) which item 37806 applies, on a
37800	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25 PATENT URAC Fee: \$677.65 UNDESCENDED person 10 years of Fee: \$521.25 UNDESCENDED	bayable for services not rendered in accordance wi v. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: $75\% = \$172.40 \ 85\% = \195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o Benefit: $75\% = \$390.95$ CHUS, excision of, when performed on a person und Benefit: $75\% = \$508.25$ D TESTIS, orchidopexy for, not being a service to of age or over. (Anaes.) (Assist.) Benefit: $75\% = \$390.95$ D TESTIS, orchidopexy for, not being a service to of age or over. (Anaes.) (Assist.)	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.) der 10 years of age (Anaes.) (Assist.) which item 37806 applies, on a
37800 37801 37803	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25 PATENT URAC Fee: \$677.65 UNDESCENDEI person 10 years of Fee: \$521.25 UNDESCENDEI person under 10 y Fee: \$677.65	bayable for services not rendered in accordance wi w. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o Benefit: 75% = \$390.95 CHUS, excision of, when performed on a person und Benefit: 75% = \$508.25 D TESTIS, orchidopexy for, not being a service to of age or over. (Anaes.) (Assist.) Benefit: 75% = \$390.95 D TESTIS, orchidopexy for, not being a service to years of age (Anaes.) (Assist.)	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.) der 10 years of age (Anaes.) (Assist.) which item 37806 applies, on a which item 37807 applies, on a
37800 37801 37803	benefits are not p and Territory law (See para TN.8.46 Fee: \$229.85 PATENT URAC Fee: \$521.25 PATENT URAC Fee: \$677.65 UNDESCENDEI person 10 years of Fee: \$521.25 UNDESCENDEI person under 10 y Fee: \$677.65	bayable for services not rendered in accordance wi w. Observe the explanatory note before submitting of explanatory notes to this Category) Benefit: 75% = \$172.40 85% = \$195.40 PAEDIATRIC GENITURINARY SUR CHUS, excision of, on a person 10 years of age or o Benefit: 75% = \$390.95 CHUS, excision of, when performed on a person und Benefit: 75% = \$508.25 D TESTIS, orchidopexy for, not being a service to of age or over. (Anaes.) (Assist.) Benefit: 75% = \$390.95 D TESTIS, orchidopexy for, not being a service to years of age (Anaes.) (Assist.) Benefit: 75% = \$508.25 D TESTIS, orchidopexy for, not being a service to years of age (Anaes.) (Assist.) Benefit: 75% = \$508.25 D TESTIS in inguinal canal close to deep inguinal	th relevant Commonwealth and State a claim. (Anaes.) GERY ver. (Anaes.) (Assist.) der 10 years of age (Anaes.) (Assist.) which item 37806 applies, on a which item 37807 applies, on a

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICAL
	orchidopexy for,	on a person under 10 years of age (Anaes.) (Assist.)
	Fee: \$782.95	Benefit: 75% = \$587.25 85% = \$701.25
	UNDESCENDEI (Assist.)	D TESTIS, revision orchidopexy for, on a person 10 years of age or over. (Anaes.)
37809	Fee: \$602.25	Benefit: 75% = \$451.70
	UNDESCENDE (Assist.)	D TESTIS, revision orchidopexy for, on a person under 10 years of age (Anaes.)
37810	Fee: \$782.95	Benefit: 75% = \$587.25
		ESTIS, exploration of groin for, not being a service associated with a service to which 06 and 37809 applies, on a person 10 years of age or over. (Anaes.) (Assist.)
37812	Fee: \$556.00	Benefit: 75% = \$417.00
		ESTIS, exploration of groin for, not being a service associated with a service to which 07 and 37810 applies, on a person under 10 years of age (Anaes.) (Assist.)
37813	Fee: \$722.80	Benefit: 75% = \$542.10
	HYPOSPADIAS (Anaes.)	, examination under anaesthesia with erection test on a person 10 years of age or over.
37815	Fee: \$92.75	Benefit: 75% = \$69.60
	HYPOSPADIAS (Anaes.)	, examination under anaesthesia with erection test, on a person under 10 years of age
37816	Fee: \$120.60	Benefit: 75% = \$90.45
	HYPOSPADIAS (Anaes.) (Assist.)	, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over
37818	Fee: \$491.45	Benefit: 75% = \$368.60 85% = \$417.75
	HYPOSPADIAS (Anaes.) (Assist.)	, glanuloplasty incorporating meatal advancement, on a person under 10 years of age
37819	Fee: \$638.90	Benefit: 75% = \$479.20 85% = \$557.20
	HYPOSPADIAS	, distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.)
37821	Fee: \$833.10	Benefit: 75% = \$624.85
	HYPOSPADIAS	, distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)
37822	Fee: \$1,083.05	Benefit: 75% = \$812.30
	HYPOSPADIAS	, proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.)
37824	Fee: \$1,158.30	Benefit: 75% = \$868.75
	-	, proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)
37825	Fee: \$1,505.80	Benefit: 75% = \$1129.35
-		, staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.)
	Fee: \$533.60	Benefit: 75% = \$400.20

T8. SUF	RGICAL OPERAT	ONS 5. UROLOGI	CAL
	HYPOSPADIA	staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.)	
37828	Fee: \$693.70	Benefit: 75% = \$520.30	
	HYPOSPADIA	staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.))
37830	Fee: \$691.40	Benefit: 75% = \$518.55 85% = \$609.70	
	HYPOSPADIA	staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.)	
37831	Fee: \$898.90	Benefit: 75% = \$674.20 85% = \$817.20	
	HYPOSPADIA: (Assist.)	repair of post-operative urethral fistula, on a person 10 years of age or over. (Anac	es.)
37833	Fee: \$329.95	Benefit: 75% = \$247.50	
	HYPOSPADIAS (Assist.)	repair of post-operative urethral fistula, on a person under 10 years of age (Anaes.	.)
37834	Fee: \$428.95	Benefit: 75% = \$321.75	
	EPISPADIAS, s	aged repair, first stage (Anaes.) (Assist.)	
37836	Fee: \$695.00	Benefit: 75% = \$521.25	
	EPISPADIAS, s	aged repair, second stage (Anaes.) (Assist.)	
37839	Fee: \$787.60	Benefit: 75% = \$590.70	
		F BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with c reimplantation (Anaes.) (Assist.)	ith
37842	Fee: \$1,529.10	Benefit: 75% = \$1146.85	
	AMBIGUOUS endoscopy (Ana	ENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or withou s.) (Assist.)	ıt
37845	Fee: \$695.00	Benefit: 75% = \$521.25	
		ENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscop (Anaes.) (Assist.)	у
37848	Fee: \$1,251.05	Benefit: 75% = \$938.30	
		ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, with or without endoscopy (Anaes.) (Assist.)	
37851	Fee: \$926.80	Benefit: 75% = \$695.10	
	URETHRAL V	LVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.)	
37854	Fee: \$366.45	Benefit: 75% = \$274.85	
T8. SUF	RGICAL OPERAT	ONS 6. CARDIO-THORA	1CIC
	Group T8. Surg	cal Operations	
		Subgroup 6. Cardio-Thoracic	
	CARDIOLOGY PROCEDURES		
38200	RIGHT HEART	CATHETERISATION, with any one or more of the following: fluoroscopy, oxime	etry,

dilution curves,	cardiac output measuren	nent by any method, shunt detection or exercise stress test	
		nent by any method, shunt detection or exercise stress test	
e: \$445.40	Benefit: 75% = \$334.05	85% = \$378.60	
ventricular punc	ture with any one or mor	recutaneous arterial puncture, arteriotomy or percutaneous re of the following: fluoroscopy, oximetry, dye dilution method, shunt detection or exercise stress test (Anaes.)	
e: \$531.55	Benefit: 75% = \$398.70	85% = \$451.85	
by any other proc	edure with any one or m	TH LEFT HEART CATHETERISATION via the right heart ore of the following: fluoroscopy, oximetry, dye dilution method, shunt detection or exercise stress test (Anaes.)	
e: \$642.65	Benefit: 75% = \$482.00	85% = \$560.95	
r more of syncop	e, atrioventricular condu	STUDY up to and including 3 catheter investigation of any action, sinus node function or simple ventricular tachycardia a service to which item 38212 or 38213 applies (Anaes.)	
e para TN.8.60 of e e: \$825.15	xplanatory notes to this Ca Benefit: 75% = \$618.90		
estigation; or con iarrhythmic drug nplete AV block;	nplex tachycardia induct testing with pre and post or intraoperative mappin	ions, or multiple catheter mapping, or acute intravenous t drug inductions; or catheter ablation to intentionally induce ng; or electrophysiological services during defibrillator with a service to which item 38209 or 38213 applies	
e para TN.8.60 of e e: \$1,372.45	xplanatory notes to this Ca Benefit: 75% = \$1029.35		
		STUDY, for follow-up testing of implanted defibrillator - not which item 38209 or 38212 applies (Anaes.)	
e: \$408.70	Benefit: 75% = \$306.55	85% = \$347.40	
the native coron	ary arteries, not being a	IY, placement of catheters and injection of opaque material service associated with a service to which item 38218, 38237, 38240 or 38246 applies (Anaes.)	
e para TN.8.52 of e e: \$354.90	xplanatory notes to this Ca Benefit: 75% = \$266.20		
h right or left hea	rt catheterisation or both	IY, placement of catheters and injection of opaque material n, or aortography, not being a service associated with a 38225, 38228, 38231, 38234, 38237, 38240 or 38246	
e para TN.8.52 of e : \$532.25	xplanatory notes to this Ca Benefit: 75% = \$399.20		
terial into free concervice associated	ronary graft(s) attached t with a service to which i	OGRAPHY placement of catheter(s) and injection of opaque to the aorta (irrespective of the number of grafts), not being item 38215, 38218, 38222, 38225, 38228, 38231, 38234,	
e para TN.8.52 of e	xplanatory notes to this Ca	tegory)	
	ves, cardiac output : \$531.55 HT HEART CA by any other proce- ves, cardiac output : \$642.65 RDIAC ELECTH more of syncop- lies, not being a se- para TN.8.60 of e : \$825.15 RDIAC ELECTH estigation; or com- arrhythmic drug- plete AV block; lantation not being a service associated : \$408.70 LECTIVE CORC the native corom 20, 38222, 38222 para TN.8.52 of e : \$354.90 LECTIVE CORC n right or left hea- vice to which iter- lies (Anaes.) para TN.8.52 of e : \$532.25 LECTIVE CORC or right or left hea- vice to which iter- lies (Anaes.) para TN.8.52 of e : \$532.25 LECTIVE CORC or right or left hea- vice to which iter- lies (Anaes.) para TN.8.52 of e : \$532.25 LECTIVE CORC or right or left hea- vice to which iter- lies (Anaes.) para TN.8.52 of e : \$532.25 LECTIVE CORC or right or left hea- vice to which iter- lies (Anaes.) para TN.8.52 of e : \$532.25 LECTIVE CORC or vice associated 37, 38240 or 382	ves, cardiac output measurements by any: \$531.55Benefit: $75\% = 398.70 CHT HEART CATHETERISATION WIby any other procedure with any one or modes, cardiac output measurements by any: \$642.65Benefit: $75\% = 482.00 RDIAC ELECTROPHYSIOLOGICAL S: more of syncope, atrioventricular conductions, not being a service associated with a: para TN.8.60 of explanatory notes to this Ca: \$825.15Benefit: $75\% = 618.90 RDIAC ELECTROPHYSIOLOGICAL S: stigation; or complex tachycardia inductarrhythmic drug testing with pre and posinplete AV block; or intraoperative mappilantation not being a service associated with a: \$1,372.45Benefit: $75\% = 1029.32 RDIAC ELECTROPHYSIOLOGICAL S: \$408.70Benefit: $75\% = 306.55 LECTIVE CORONARY ANGIOGRAPHthe native coronary arteries, not being a20, 38222, 38225, 38228, 38231, 38234,: \$ara TN.8.52 of explanatory notes to this Ca: \$354.90Benefit: $75\% = 266.20 LECTIVE CORONARY ANGIOGRAPHthe native coronary arteries, not being a20, 38222, 38225, 38228, 38231, 38234,: para TN.8.52 of explanatory notes to this Ca: \$354.90Benefit: $75\% = 266.20 LECTIVE CORONARY ANGIOGRAPHthe right or left heart catheterisation or bothvice to which item 38215, 38220, 38222, lies (Anaes.): para TN.8.52 of explanatory notes to this Ca: \$532.25Benefit: $75\% = 399.20 LECTIVE CORONARY GRAFT ANGIOerial into free coronary graft(s) attached	

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	Fee: \$177.40 Benefit: 75% = \$133.05 85% = \$150.80	
	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement opaque material into direct internal mammary artery graft(s) to one (irrespective of the number of grafts), not being a service associated 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38240	or more coronary arteries I with a service to which item 38215,
38222	(See para TN.8.52 of explanatory notes to this Category) Fee: \$354.90 Benefit: 75% = \$266.20 85% = \$301.70	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathet into the native coronary arteries and placement of catheter(s) and in coronary graft(s) attached to the aorta (irrespective of the number of associated with a service to which item 38215, 38218, 38220, 38222 38240 or 38246 applies (Anaes.)	jection of opaque material into free f grafts), not being a service
38225	(See para TN.8.52 of explanatory notes to this Category) Fee: \$532.35 Benefit: 75% = \$399.30 85% = \$452.50	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathet into the native coronary arteries and placement of catheter(s) and in internal mammary artery graft(s) to one or more coronary arteries (i not being a service associated with a service to which item 38215, 3 38234, 38237, 38240 or 38246 applies (Anaes.)	jection of opaque material into direct irrespective of the number of grafts),
38228	(See para TN.8.52 of explanatory notes to this Category) Fee: \$709.90 Benefit: 75% = \$532.45 85% = \$628.20	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathete into the native coronary arteries and placement of catheter(s) and in free coronary graft(s) attached to the aorta (irrespective of the numb catheter(s) and injection of opaque material into direct internal man coronary arteries (irrespective of the number of grafts), not being a which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 382	jection of opaque material into the ber of grafts), and placement of mmary artery graft(s) to one or more service associated with a service to
38231	(See para TN.8.52 of explanatory notes to this Category) Fee: \$887.25 Benefit: 75% = \$665.45 85% = \$805.55	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathet with right or left heart catheterisation or both, or aortography and pl of opaque material into free coronary graft(s) attached to the aorta (not being a service associated with a service to which item 38215, 3 38231, 38237, 38240 or 38246 applies (Anaes.)	lacement of catheter(s) and injection irrespective of the number of grafts),
38234	(See para TN.8.52 of explanatory notes to this Category) Fee: \$709.75 Benefit: 75% = \$532.35 85% = \$628.05	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathet with right or left heart catheterisation or both, or aortography and pl of opaque material into direct internal mammary artery graft(s) to o (irrespective of the number of grafts), not being a service associated 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38240	lacement of catheter(s) and injection ne or more coronary arteries I with a service to which item 38215,
38237	(See para TN.8.52 of explanatory notes to this Category) Fee: \$887.20 Benefit: 75% = \$665.40 85% = \$805.50	
38240	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathet with right or left heart catheterisation or both, or aortography and pl of opaque material into free coronary graft(s) attached to the aorta (lacement of catheter(s) and injection

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	and placement of catheter(s) and injection of opaque magraft(s) to one or more coronary arteries (irrespective of associated with a service to which item 38215, 38218, 3838237 or 38246 applies (Anaes.)	the number of grafts), not being a service
	(See para TN.8.52 of explanatory notes to this Category) Fee: \$1,064.60 Benefit: 75% = \$798.45 85% = \$98	2.90
	USE OF A CORONARY PRESSURE WIRE during self fractional flow reserve (FFR) and coronary flow reserve artery or graft lesions (stenosis of 30-70%), to determine where previous stress testing has either not been perform	(CFR) in one or more intermediate coronary whether revascularisation should be performed
38241	Fee: \$469.70 Benefit: 75% = \$352.30 85% = \$39	9.25
	PLACEMENT OF CATHETER(S) and injection of opag graft(s) prior to any coronary interventional procedure, r which item 38246 applies (Anaes.)	
38243	(See para TN.8.52 of explanatory notes to this Category) Fee: \$443.60 Benefit: 75% = \$332.70 85% = \$37	7.10
	SELECTIVE CORONARY ANGIOGRAPHY, placeme with right or left heart catheterisation or both, or aortogr any coronary interventional procedure, not being a servic 38215, 38218, 38220, 38222, 38225, 38228, 38231, 382	aphy followed by placement of catheters prior to ce associated with a service to which item
38246	(See para TN.8.52 of explanatory notes to this Category) Fee: \$887.20 Benefit: 75% = \$665.40 85% = \$80	5.50
	TEMPORARY TRANSVENOUS PACEMAKING ELE	ECTRODE, insertion of (Anaes.)
38256	Fee: \$267.25 Benefit: 75% = \$200.45 85% = \$22	7.20
	BALLOON VALVULOPLASTY OR ISOLATED ATR catheterisations before and after balloon dilatation (Anac	
38270	Fee: \$912.30 Benefit: 75% = \$684.25 85% = \$83	0.60
	ATRIAL SEPTAL DEFECT closure, with septal occlud approach (Anaes.) (Assist.)	er or other similar device, by transcatheter
38272	Fee: \$912.30 Benefit: 75% = \$684.25 85% = \$83	0.60
	Patent ductus arteriosus, transcatheter closure of, including cardiac catheterisation and any imaging associated with the service (Anaes.) (Assist.)	
38273	Fee: \$912.30 Benefit: 75% = \$684.25	
	Ventricular septal defect, transcatheter closure of, with it (Assist.)	maging and cardiac catheterisation (Anaes.)
38274	Fee: \$912.30 Benefit: 75% = \$684.25	
	MYOCARDIAL BIOPSY, by cardiac catheterisation (A	naes.)
38275	Fee: \$298.20 Benefit: 75% = \$223.65 85% = \$25	3.50
38276	Transcatheter occlusion of left atrial appendage, and car practitioner, for stroke prevention in a patient who has no contraindication to life-long oral anticoagulation therapy	diac catheterisation performed by the same on-valvular atrial fibrillation and a

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORAC	SIC
	demonstrated by:	
	(a) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or	.1
	(b) at least 2 of the following risk factors:	
	(i) an age of 65 years or more;	
	(ii) hypertension;	
	(iii) diabetes mellitus;	
	(iv) heart failure or left ventricular ejection fraction of 35% or less (or both);	
	(v) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque)	
	(Anaes.) (Assist.)	
	(See para TN.8.132 of explanatory notes to this Category) Fee: \$912.30 Benefit: 75% = \$684.25	
	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where:	3
	- a diagnosis has not been achieved through all other available cardiac investigations; and	
	- a neurogenic cause is not suspected; and	
	- it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death.	gh
	including initial programming and testing, as an admitted patient in an approved hospital (Anaes.)	
38285	(See para TN.8.61 of explanatory notes to this Category) Fee: \$192.90 Benefit: 75% = \$144.70 85% = \$164.00	
	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospita (Anaes.)	al
38286	Fee: \$173.75 Benefit: 75% = \$130.35 85% = \$147.70	
	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if:	
	(a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and	•
	(b) the bases of the diagnosis included the following:	
	(i) the medical history of the patient;	
	(ii) physical examination;	
	(iii) brain and carotid imaging;	
New 38288 S	(iv) cardiac imaging;	

T8. SUF	GICAL OPERAT	IONS	6. CARDIO-THORACIC
	(v) surface ECG	testing including 24-hour Holte	er monitoring; and
	(c) atrial fibrillat	ion is suspected; and	
	(d) the patient:		
	(i) does not have	a permanent indication for oral	l anticoagulants; or
	(ii) does not have	e a permanent oral anticoagulan	nts contraindication;
	including initial	programming and testing	
	(Anaes.)		
	Fee: \$192.90	Benefit: 75% = \$144.70 85	85% = \$164.00
		CATHETER BASE	D ARRHYTHMIA ABLATION
	ABLATION OF chamber (Anaes.		R FOCUS or isolation procedure involving 1 atrial
38287	Fee: \$2,098.45	Benefit: 75% = \$1573.85	85% = \$2016.75
			OR FOCI, or isolation procedure involving both atrial atrial fibrillation (Anaes.) (Assist.)
38290	Fee: \$2,671.95	Benefit: 75% = \$2004.00	
		R ARRHYTHMIA with mappir ical studies performed on the sa	ng and ablation, including all associated ame day (Anaes.) (Assist.)
38293	Fee: \$2,868.05	Benefit: 75% = \$2151.05	85% = \$2786.35
		ENDOVASCULAR INT	ERVENTIONAL PROCEDURES
			ΓY of 1 coronary artery, percutaneous or by open vices or preparation, and excluding aftercare (Anaes.)
38300	Fee: \$515.35	Benefit: 75% = \$386.55 85	25% = \$438.05
		xcluding associated radiologica	TY of more than 1 coronary artery, percutaneous or by al services or preparation and excluding aftercare
38303	Fee: \$660.80	Benefit: 75% = \$495.60 85	25% = \$579.10
	of coronary arter		e occlusional site, including associated balloon dilatation posure, excluding associated radiological services, (Assist.)
38306	(See para TN.8.62 Fee: \$762.35	of explanatory notes to this Catego Benefit: 75% = \$571.80 8	
		US TRANSLUMINAL ROTA angioplasty with no stent inse	TIONAL ATHERECTOMY of 1 coronary artery, ertion, where:
38309	- no lesion of the	he coronary artery has been ster	nted; and

T8. SUR	RGICAL OPERATIONS	6. CARDIO-THORACIC
	- each lesion of the coronary artery is complex and heavily calcifi	ied; and
	- balloon angioplasty with or without stenting is not suitable;	
	excluding associated radiological services or preparation, and exclu	iding aftercare (Anaes.) (Assist.)
	(See para TN.8.41 of explanatory notes to this Category) Fee: \$885.45 Benefit: 75% = \$664.10 85% = \$803.75	
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERE including balloon angioplasty with insertion of 1 or more stents, wh	
	- no lesion of the coronary artery has been stented; and	
	- each lesion of the coronary artery is complex and heavily calcifi	ied; and
	- balloon angioplasty with or without stenting is not suitable;	
	excluding associated radiological services or preparation, and exclu	iding aftercare (Anaes.) (Assist.)
38312	(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,132.35 Benefit: 75% = \$849.30 85% = \$1050.65	
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERE artery, including balloon angioplasty with no stent insertion, where	5
	- no lesion of the coronary arteries has been stented; and	
	- each lesion of the coronary arteries is complex and heavily calci	ified; and
	- balloon angioplasty with or without stenting is not suitable;	
	excluding associated radiological services or preparation, and exclu	iding aftercare (Anaes.) (Assist.)
38315	(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,215.85 Benefit: 75% = \$911.90 85% = \$1134.15	
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERE artery, including balloon angioplasty, with insertion of 1 or more st	5
	- no lesion of the coronary arteries has been stented; and	
	- each lesion of the coronary arteries is complex and heavily calci	ified; and
	- balloon angioplasty with or without stenting is not suitable,	
	excluding associated radiological services or preparation, and exclu	iding aftercare (Anaes.) (Assist.)
38318	(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,586.35 Benefit: 75% = \$1189.80 85% = \$1504.65	
	MISCELLANEOUS CARDIAC PROCE	EDURES
	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRO replacement of, including cardiac electrophysiological services whe (Anaes.)	
38350	(See para TN.8.60 of explanatory notes to this Category) Fee: \$638.65 Benefit: 75% = \$479.00	
38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or re	eplacement of, not for cardiac

T8. SUR	IRGICAL OPERATIONS 6. CA	6. CARDIO-THORACIC	
	resynchronisation therapy, including cardiac electrophysiological services where use implantation (Anaes.)	d for pacemaker	
	(See para TN.8.60 of explanatory notes to this Category) Fee: \$255.45 Benefit: 75% = \$191.60		
	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, re replacement of, including cardiac electrophysiological services where used for pacer (Anaes.)		
38356	(See para TN.8.60 of explanatory notes to this Category) Fee: \$837.35 Benefit: 75% = \$628.05		
	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, method where the leads have been in situ for greater than six months and require ren stylets, snares and/or extraction sheaths in a facility where cardiac surgery is availab with item 61109 or 60509 (Anaes.) (Assist.)	noval with locking	
38358	(See para TN.8.64 of explanatory notes to this Category) Fee: \$2,868.05 Benefit: 75% = \$2151.05		
	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.)		
38359	Fee: \$133.55 Benefit: 75% = \$100.20 85% = \$113.55		
	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.)		
38362	Fee: \$384.95 Benefit: 75% = \$288.75 85% = \$327.25		
	Permanent cardiac synchronisation device (including a cardiac synchronisation device defibrillation), insertion, removal or replacement of, for a patient who:	ce that is capable of	
	(a) has:		
	(i) moderate to severe chronic heart failure (New York Heart Association (NYI despite optimised medical therapy; and	HA) class III or IV)	
	(ii) sinus rhythm; and		
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and		
	(iv) a QRS duration greater than or equal to 120 ms; or		
	(b) satisfied the requirements mentioned in paragraph (a) immediately before the in resynchronisation therapy device and transvenous left ventricle electrode (Anaes		
38365	(See para TN.8.63 of explanatory notes to this Category) Fee: \$255.45 Benefit: 75% = \$191.60		
	Permanent transvenous left ventricular electrode, insertion, removal or replacement of coronary sinus, for the purpose of cardiac resynchronisation therapy, including right and any associated venogram of left ventricular veins, other than a service associated which item 35200 or 38200 applies, for a patient who:	heart catheterisation	
	(a) has:		
	 (i) moderate to severe chronic heart failure (New York Heart Association (NYI despite optimised medical therapy; and 	HA) class III or IV)	
38368			

T8. SURG	GICAL OPERATIONS 6. CARDIO-THORACIO
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 120 ms; or
	(b) has:
	 (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 150 ms; or
	(c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.)
	(See para TN.8.63 of explanatory notes to this Category) Fee: \$1,224.60 Benefit: 75% = \$918.45
	Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of for a patient who:
	(a) has:
	 (i) moderate to severe chronic heart failure (New York Heart Association ((NYHA) class III or IV) despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 120 ms; or
	(b) has:
	(i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 150 ms (Anaes.)
38371	(See para TN.8.65 of explanatory notes to this Category) Fee: \$287.85 Benefit: 75% = \$215.90
	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in:
38384	- patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after

T8. SUI	RGICAL OPERATIONS	6. CARDIO-THORACIC
	a myocardial infarct when the patient has received optimised media	cal therapy; or
	- patients with chronic heart failure associated with mild to moderat and a left ventricular ejection fraction less than or equal to 35% who optimised medical therapy.	
	Not being a service associated with a service to which item 38213 app	plies (Anaes.) (Assist.)
	Fee: \$1,052.65 Benefit: 75% = \$789.50 85% = \$970.95	
	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replace of sudden cardiac death in:	cement of for, primary prevention
	- patients with a left ventricular ejection fraction of less than or equal a myocardial infarct when the patient has received optimised media	
	- patients with chronic heart failure associated with mild to moderat and a left ventricular ejection fraction less than or equal to 35% who ptimised medical therapy.	
	Not being a service associated with a service to which item 38213 app of cardiac resynchronisation therapy (Anaes.) (Assist.)	plies, not for defibrillators capable
38387	Fee: \$287.85 Benefit: 75% = \$215.90 85% = \$244.70	
	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion defibrillation electrodes for - not for patients with heart failure or as pr arrhythmias. Not being a service associated with a service to which it (Assist.)	rimary prevention for tachycardia
38390	Fee: \$1,052.65 Benefit: 75% = \$789.50 85% = \$970.95	
	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replace heart failure or as primary prevention for tachycardia arrhythmias. No service to which item 38213 applies. (Anaes.) (Assist.)	
38393	Fee: \$287.85 Benefit: 75% = \$215.90 85% = \$244.70	
	THORACIC SURGERY	
	EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.)	
38415	Fee: \$399.35 Benefit: 75% = \$299.55 85% = \$339.45	
	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Ass	sist.)
38418	Fee: \$958.40 Benefit: 75% = \$718.80	

T8. SUF	GICAL OPERATIO	NS 6. CARDIO-THORACIC
	THORACOTOMY	with pulmonary decortication (Anaes.) (Assist.)
38421	Fee: \$1,532.00	Benefit: 75% = \$1149.00
	THORACOTOMY (Anaes.) (Assist.)	with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts
38424	Fee: \$958.40	Benefit: 75% = \$718.80
	THORACOPLAST	Y (complete) - 3 or more ribs (Anaes.) (Assist.)
38427	Fee: \$1,183.40	Benefit: 75% = \$887.55
	THORACOPLAST	Y (in stages) each stage (Anaes.) (Assist.)
38430	Fee: \$609.90	Benefit: 75% = \$457.45
		, with or without division of pleural adhesions, including insertion of intercostal ssary, with or without biopsy (Anaes.)
38436	Fee: \$249.75	Benefit: 75% = \$187.35
		AY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a m 38418 applies (Anaes.) (Assist.)
38438	Fee: \$1,532.00	Benefit: 75% = \$1149.00
	LUNG, wedge resea	ction of (Anaes.) (Assist.)
38440	Fee: \$1,147.20	Benefit: 75% = \$860.40
	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.)	
38441	Fee: \$1,815.20	Benefit: 75% = \$1361.40
	THORACOTOMY	or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.)
38446	Fee: \$1,183.40	Benefit: 75% = \$887.55
	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.)	
38447	Fee: \$1,532.00	Benefit: 75% = \$1149.00
	MEDIASTINUM, c	ervical exploration of, with or without biopsy (Anaes.) (Assist.)
38448	Fee: \$363.05	Benefit: 75% = \$272.30
	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.)	
38449	Fee: \$2,143.20	Benefit: 75% = \$1607.40
	PERICARDIUM, tr	ansthoracic open surgical drainage of (Anaes.) (Assist.)
38450	Fee: \$856.65	Benefit: 75% = \$642.50
		ubxiphoid open surgical drainage of (Anaes.) (Assist.)
38452	Fee: \$573.70	Benefit: 75% = \$430.30
38453		on and repair without cardiopulmonary bypass (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATIONS		6. CARDIO-THORACIC	
	Fee: \$1,720.90	Benefit: 75% = \$1290.70		
	TRACHEAL EX	CISION AND REPAIR OF, wi	th cardiopulmonary bypass (Anaes.) (Assist.)	
38455	Fee: \$2,327.70	Benefit: 75% = \$1745.80		
		on more than 1 of those organs,	gs, great vessels, bronchial tree, oesophagus or not being a service to which another item in this Group	
38456	Fee: \$1,532.00	Benefit: 75% = \$1149.00		
	PECTUS EXCAV	ATUM or PECTUS CARINA	TUM, repair or radical correction of (Anaes.) (Assist.)	
38457	Fee: \$1,430.25	Benefit: 75% = \$1072.70		
	PECTUS EXCA	ATUM, repair of, with implar	ntation of subcutaneous prosthesis (Anaes.) (Assist.)	
38458	Fee: \$762.35	Benefit: 75% = \$571.80		
		E OR WIRES, removal of (Ana	es.)	
29160	Fee: \$275.40	Benefit: 75% = \$206.55		
38460			involving reopening of the mediastinum (Anaes.)	
			involving reopening of the inculasinum (rulaes.)	
38462	Fee: \$326.45	Benefit: 75% = \$244.85		
	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.)			
38464	Fee: \$354.80	Benefit: 75% = \$266.10		
	-	eration on, for dehiscence or in (Anaes.) (Assist.)	fection involving reopening of the mediastinum, with or	
38466	Fee: \$958.00	Benefit: 75% = \$718.50		
		MEDIASTINUM, reoperation	n for infection of, involving muscle advancement flaps	
38468	468 Fee: \$1,476.15 Benefit: 75% = \$1107.15			
		MEDIASTINUM, reoperation tum (Anaes.) (Assist.)	n for infection of, involving muscle advancement flaps	
38469	Fee: \$1,720.90	Benefit: 75% = \$1290.70		
		CARDIAC SUR	GERY PROCEDURES	
	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.)		insertion of, by thoracotomy or sternotomy (Anaes.)	
38470	(See para TN.8.67 of explanatory notes to this Category) Fee: \$958.40 Benefit: 75% = \$718.80		ry)	
PERMANENT PA		ACEMAKER ELECTRODE, i	nsertion by open surgical approach (Anaes.) (Assist.)	
38473	(See para TN.8.67 of explanatory notes to this Category) Fee: \$573.70 Benefit: 75% = \$430.30		ry)	
		VALVULA	R PROCEDURES	
38475	VALVE ANNUL	OPLASTY without insertion o	f ring, not being a service associated with a service to	

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	which item 38480 or 38481 applies (Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$831.75 Benefit: 75% = \$623.85	
	VALVE ANNULOPLASTY with insertion of ring not being a servic (Anaes.) (Assist.)	e to which item 38478 applies
38477	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,003.35 Benefit: 75% = \$1502.55	
	VALVE ANNULOPLASTY with insertion of ring performed in conj (Anaes.) (Assist.)	junction with item 38480 or 38481
38478	(See para TN.8.67 of explanatory notes to this Category) Fee: \$970.40 Benefit: 75% = \$727.80	
	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.)	
38480	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,003.35 Benefit: 75% = \$1502.55	
	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.)	
38481	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,280.65 Benefit: 75% = \$1710.50	
	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, no 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assis	
38483	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,720.90 Benefit: 75% = \$1290.70	
	MITRAL ANNULUS, reconstruction of, after decalcification, when p surgery (Anaes.) (Assist.)	performed in association with valve
38485	(See para TN.8.67 of explanatory notes to this Category) Fee: \$817.10 Benefit: 75% = \$612.85	
	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)	
38487	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,720.90 Benefit: 75% = \$1290.70	
	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANIC (Assist.)	CAL PROSTHESIS (Anaes.)
38488	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.60 Benefit: 75% = \$1432.20	
	VALVE REPLACEMENT with allograft (subcoronary or cylindrical (Anaes.) (Assist.)	implant), or unstented xenograft
38489	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,271.05 Benefit: 75% = \$1703.30	
	SUB-VALVULAR STRUCTURES, reconstruction and re-implantati tricuspid valve replacement (Anaes.) (Assist.)	ion of, associated with mitral and
38490	(See para TN.8.67 of explanatory notes to this Category) Fee: \$554.55 Benefit: 75% = \$415.95	
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in as	ssociation with heart valve surgery

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	(Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,957.60 Benefit: 75% = \$1468.20	
	TAVI, for the treatment of symptomatic severe aortic stenos unless transfemoral delivery is contraindicated or not feasibl a TAVI Practitioner – includes all intraoperative diagnostic i upon the TAVI Patient.	e, in a TAVI Hospital on a TAVI Patient by
	(Not payable more than once per patient in a five year period	l.) (Anaes.) (Assist.)
38495	(See para AN.33.1, TN.8.135 of explanatory notes to this Category Fee: \$1,432.20 Benefit: 75% = \$1074.15 85% = \$1350.	
	SURGERY FOR ISCHAEMIC H	EART DISEASE
	ARTERY HARVESTING (other than internal mammary), for	or coronary artery bypass (Anaes.) (Assist.)
38496	(See para TN.8.67 of explanatory notes to this Category) Fee: \$623.95 Benefit: 75% = \$468.00	
	CORONARY ARTERY BYPASS with cardiopulmonary by only, including harvesting of vein graft material where perfo service to which items 38498, 38500, 38501, 38503 or 38504	rmed, not being a service asociated with a
38497	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,047.60 Benefit: 75% = \$1535.70	
	CORONARY ARTERY BYPASS with the aid of tissue stab bypass, using saphenous vein graft or grafts only, including performed, either via a median sternotomy or other minimall perfusionist is present, not being a service associated with a 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.)	harvesting of vein graft material where ly invasive technique and where a stand-by
38498	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,047.60 Benefit: 75% = \$1535.70	
	CORONARY ARTERY BYPASS with cardiopulmonary by without vein graft or grafts, including harvesting of internal where performed, not being a service associated with a servi 38503 or 38504 apply (Anaes.) (Assist.)	mammary artery or vein graft material
38500	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,200.00 Benefit: 75% = \$1650.00	
	CORONARY ARTERY BYPASS with the aid of tissue state bypass, using single arterial graft, with or without vein graft mammary artery or vein graft material where performed, eith minimally invasive technique and where a stand-by perfusio with a service to which items 38497, 38498, 38500, 38503,	or grafts, including harvesting of internal her via a median sternotomy or other nist is present, not being a service associated
38501	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,200.00 Benefit: 75% = \$1650.00	
	CORONARY ARTERY BYPASS with cardiopulmonary by without vein graft or grafts, including harvesting of internal where performed, not being a service associated with a servi 38501 or 38504 apply (Anaes.) (Assist.)	mammary artery or vein graft material
38503	(See para TN.8.68, TN.8.67 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	Fee: \$2,388.70 Benefit: 75% = \$1791.55	
	CORONARY ARTERY BYPASS with the aid of tissue stab bypass, using 2 or more arterial grafts, with or without vein g internal mammary artery or vein graft material where perform minimally invasive technique and where a stand-by perfusion with a service to which items 38497, 38498, 38500, 38501, 3	graft or grafts, including harvesting of ned, either via a median sternotomy or other nist is present, not being a service associated
38504	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,388.70 Benefit: 75% = \$1791.55	
	CORONARY ENDARTERECTOMY, by open operation, in each vessel (Anaes.) (Assist.)	cluding repair with 1 or more patch grafts,
38505	(See para TN.8.67 of explanatory notes to this Category) Fee: \$277.25 Benefit: 75% = \$207.95	
	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.)	(Assist.)
38506	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,626.25 Benefit: 75% = \$1219.70	
	LEFT VENTRICULAR ANEURYSM resection with primar	y repair (Anaes.) (Assist.)
38507	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.20 Benefit: 75% = \$1431.90	
	LEFT VENTRICULAR ANEURYSM resection with patch r (Assist.)	reconstruction of the left ventricle (Anaes.)
38508	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,388.70 Benefit: 75% = \$1791.55	
	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.)	
38509	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,388.70 Benefit: 75% = \$1791.55	
	ARRHYTHMIA SURG	ERY
	DIVISION OF ACCESSORY PATHWAY, isolation proceed perinodal tissues involving 1 atrial chamber only (Anaes.) (A	
38512	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,098.45 Benefit: 75% = \$1573.85	
	DIVISION OF ACCESSORY PATHWAY, isolation procedu perinodal tissues involving both atrial chambers and includin (Anaes.) (Assist.)	
38515	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,671.95 Benefit: 75% = \$2004.00	
	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeo (Anaes.) (Assist.)	
38518	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,868.05 Benefit: 75% = \$2151.05	
	PROCEDURES ON THORA	CIC AORTA
38550	ASCENDING THORACIC AORTA, repair or replacement or coronary artery implantation (Anaes.) (Assist.)	of, not involving valve replacement or repair

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,146.15 Benefit: 75% = \$1609.65	
	ASCENDING THORACIC AORTA, repair or replacement of, wir without implantation of coronary arteries (Anaes.) (Assist.)	th aortic valve replacement or repair,
38553	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,719.75 Benefit: 75% = \$2039.85	
	ASCENDING THORACIC AORTA, repair or replacement of, wir and implantation of coronary arteries (Anaes.) (Assist.)	th aortic valve replacement or repair,
38556	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,104.70 Benefit: 75% = \$2328.55	
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair replacement or repair or coronary artery implantation (Anaes.) (As	
38559	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,531.00 Benefit: 75% = \$1898.25	
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair replacement or repair, without implantation of coronary arteries (A	
38562	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,104.70 Benefit: 75% = \$2328.55	
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair replacement or repair, and implantation of coronary arteries (Anae	
38565	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,482.25 Benefit: 75% = \$2611.70	
	DESCENDING THORACIC AORTA, repair or replacement of, w bypass, by open exposure, percutaneous or endovascular means (A	
38568	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,862.95 Benefit: 75% = \$1397.25	
	DESCENDING THORACIC AORTA, repair or replacement of, u (Anaes.) (Assist.)	sing shunt or cardiopulmonary bypass
38571	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,051.75 Benefit: 75% = \$1538.85	
	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DIS procedures on the thoracic aorta (Anaes.) (Assist.)	SECTION, in conjunction with
38572	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,987.05 Benefit: 75% = \$1490.30	
	CANNULATION FOR, and supervision and monitoring of, the ad perfusion during deep hypothermic arrest (Assist.)	Iministration of retrograde cerebral
38577	(See para TN.8.67 of explanatory notes to this Category) Fee: \$554.55 Benefit: 75% = \$415.95	
	TECHNIQUES FOR PRESERVATION OF AR	RESTED HEART
	CANNULATION of the coronary sinus for, and supervision of, th crystalloid for cardioplegia, including pressure monitoring (Assist.	
38588	(See para TN.8.67 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATI	ONS	6. CARDIO-THORACIO
	Fee: \$416.05	Benefit: 75% = \$312.05	
		CIRCULATOR	Y SUPPORT PROCEDURES
			onary bypass excluding post-operative management, not hich another item in this Subgroup applies (Anaes.)
38600	(See para TN.8.67 o Fee: \$1,532.00	of explanatory notes to this Cate Benefit: 75% = \$1149.00	egory)
	PERIPHERAL C. (Anaes.) (Assist.)	-	ulmonary bypass excluding post-operative management
38603	(See para TN.8.67 o Fee: \$958.40	of explanatory notes to this Cate Benefit: 75% = \$718.80	egory)
	INTRA-AORTIC	C BALLOON PUMP, insertion	on of, by arteriotomy (Anaes.) (Assist.)
38609	(See para TN.8.67 o Fee: \$479.15	of explanatory notes to this Cate Benefit: 75% = \$359.40	egory)
	INTRA-AORTIC (Assist.)	E BALLOON PUMP, remova	al of, with closure of artery by direct suture (Anaes.)
38612	(See para TN.8.67 o Fee: \$537.10	of explanatory notes to this Cate Benefit: 75% = \$402.85	
	INTRA-AORTIC (Assist.)	E BALLOON PUMP, remova	al of, with closure of artery by patch graft (Anaes.)
38613	(See para TN.8.67 o Fee: \$674.05	of explanatory notes to this Cate Benefit: 75% = \$505.55	egory)
	Insertion of a left	or right ventricular assist de	vice, for use as:
			ients with refractory heart failure who are:
	(i) currently of	on a heart transplant waiting	list, or
	(ii) expected the ventricular	to be suitable candidates for	cardiac transplantation following a period of support on
	assist device	; or	
	(b) acute post ca	ardiotomy support for failure	e to wean from cardiopulmonary transplantation; or
	(c) cardio-respin support of less that		iac failure which is likely to recover with short term
	weeks;		
		atients with heart failure who	a ventricular assist device as destination therapy in the o are not expected to be suitable candidates for cardiac
38615	(See para TN.8.67 o Fee: \$1,532.00	of explanatory notes to this Cate Benefit: 75% = \$1149.00	egory)
38618	Insertion of a left	and right ventricular assist c	levice, for use as:

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	(a) a bridge to cardiac transplantation in patients with refractory	heart failure who are:
	(i) currently on a heart transplant waiting list, or	
	(ii) expected to be suitable candidates for cardiac transplantat the ventricular	ion following a period of support on
	assist device; or	
	(b) acute post cardiotomy support for failure to wean from cardi	opulmonary transplantation; or
	(c) cardio-respiratory support for acute cardiac failure which is support of less than 6	likely to recover with short term
	weeks;	
	not being a service associated with the use of a ventricular assist of management of patients with heart failure who are not expected to transplantation (Anaes.) (Assist.)	1.
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.60 Benefit: 75% = \$1432.20	
	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal (Anaes.) (Assist.)	of, as an independent procedure
38621	(See para TN.8.67 of explanatory notes to this Category) Fee: \$762.35 Benefit: 75% = \$571.80	
	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, remova (Anaes.) (Assist.)	al of, as an independent procedure
38624	(See para TN.8.67 of explanatory notes to this Category) Fee: \$856.65 Benefit: 75% = \$642.50	
	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPA DEVICE CANNULAE, adjustment and re-positioning of, by open these devices (Anaes.) (Assist.)	
38627	(See para TN.8.67 of explanatory notes to this Category) Fee: \$669.60 Benefit: 75% = \$502.20	
	RE-OPERATION	
	PATENT DISEASED coronary artery bypass vein graft or grafts, oversewing of (Anaes.) (Assist.)	dissection, disconnection and
38637	(See para TN.8.67 of explanatory notes to this Category) Fee: \$554.55 Benefit: 75% = \$415.95	
	RE-OPERATION via median sternotomy, for any procedure, incl where the time taken to divide the adhesions is 45 minutes or less	
38640	(See para TN.8.69, TN.8.67 of explanatory notes to this Category) Fee: \$958.40 Benefit: 75% = \$718.80	
	MISCELLANEOUS CARDIOTHORACIC SURG	ICAL PROCEDURES
38643	THORACOTOMY OR STERNOTOMY involving division of ad the adhesions exceeds 45 minutes (Anaes.) (Assist.)	hesions where the time taken to divide

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIO
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,067.40 Benefit: 75% = \$800.55
	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.)
38647	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90
	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.)
38650	(See para TN.8.67 of explanatory notes to this Category)Fee: $$1,909.60$ Benefit: $75\% = 1432.20
	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.)
38653	(See para TN.8.67 of explanatory notes to this Category)Fee: $\$1,909.60$ Benefit: $75\% = \$1432.20$
	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for a patient who:
	(a) has:
	 (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 120 ms; or
	(b) has:
	 (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 150 ms; or
	(c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode
	(Anaes.) (Assist.)
38654	(See para TN.8.63, TN.8.67 of explanatory notes to this Category) Fee: $$1,224.60$ Benefit: 75% = \$918.45
	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.)
38656	(See para TN.8.67 of explanatory notes to this Category) Fee: \$958.40 Benefit: 75% = \$718.80
	CARDIAC TUMOURS
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch

T8. SUR	RGICAL OPERATIONS 6. CARDIO-THOP	RACIC	
	or conduit reconstruction (Anaes.) (Assist.)		
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,909.20 Benefit: 75% = \$1431.90		
	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.)	ng	
38673	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,148.85 Benefit: 75% = \$1611.65		
	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes. (Assist.))	
38677	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,010.35 Benefit: 75% = \$1507.80		
	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including r or reconstruction (Anaes.) (Assist.)	repair	
38680	(See para TN.8.70 of explanatory notes to this Category) Fee: \$2,384.55 Benefit: 75% = \$1788.45 85% = \$2302.85		
	CONGENITAL CARDIAC SURGERY		
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligat without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	ion of,	
38700	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,067.40 Benefit: 75% = \$800.55		
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligat with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)	ion of,	
38703	(See para TN.8.67 of explanatory notes to this Category)Fee: $$1,924.10$ Benefit: $75\% = 1443.10		
	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)		
38706	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,822.40 Benefit: 75% = \$1366.80		
	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (An (Assist.)	aes.)	
38709	(See para TN.8.67 of explanatory notes to this Category)Fee: $$2,134.50$ Benefit: $75\% = 1600.90		
	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.)		
38712	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,563.15 Benefit: 75% = \$1922.40		
	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypa congenital heart disease (Anaes.) (Assist.)	ass, for	
38715	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,706.30 Benefit: 75% = \$1279.75		
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	VENA CAVA, anastomosis or repair of, without cardiopulmon (Anaes.) (Assist.)	ary bypass, for congenital heart disease
38721	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,495.80 Benefit: 75% = \$1121.85	
	VENA CAVA, anastomosis or repair of, with cardiopulmonary (Anaes.) (Assist.)	v bypass, for congenital heart disease
38724	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	INTRATHORACIC VESSELS, anastomosis or repair of, with service to which item 38700, 38703, 38706, 38709, 38712, 387 congenital heart disease (Anaes.) (Assist.)	
38727	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,495.80 Benefit: 75% = \$1121.85	
	INTRATHORACIC VESSELS, anastomosis or repair of, with service to which item 38700, 38703, 38706, 38709, 38712, 387 congenital heart disease (Anaes.) (Assist.)	
38730	Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUN bypass, for congenital heart disease (Anaes.) (Assist.)	T, creation of, without cardiopulmonary
38733	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,495.80 Benefit: 75% = \$1121.85	
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUN bypass, for congenital heart disease (Anaes.) (Assist.)	T, creation of, with cardiopulmonary
38736	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	ATRIAL SEPTECTOMY, with or without cardiopulmonary by (Anaes.) (Assist.)	ypass, for congenital heart disease
38739	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,924.10 Benefit: 75% = \$1443.10	
	ATRIAL SEPTAL DEFECT, closure by open exposure direct s disease (Anaes.) (Assist.)	suture or patch, for congenital heart
38742	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,924.10 Benefit: 75% = \$1443.10	
	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart d	isease (Anaes.) (Assist.)
38745	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,134.50 Benefit: 75% = \$1600.90	
	VENTRICULAR SEPTECTOMY, for congenital heart disease	e (Anaes.) (Assist.)
20740	(See para TN.8.67 of explanatory notes to this Category)	
38748	Fee: \$2,134.50 Benefit: 75% = \$1600.90	

T8. SUF	RGICAL OPERATIO	ONS		6. CARDIO-THORACIO	
	Ventricular septal	defect, closure by direct sutu	re or patch (Anaes.) (Assist.)		
		f explanatory notes to this Categ	ory)		
38751	Fee: \$2,134.50	Benefit: 75% = \$1600.90			
	INTRAVENTRIC (Assist.)	CULAR BAFFLE OR COND	UIT, insertion of, for congeni	tal heart disease (Anaes.)	
38754	(See para TN.8.67 c Fee: \$2,671.95	f explanatory notes to this Categ Benefit: 75% = \$2004.00	ory)		
	EXTRACARDIA	C CONDUIT, insertion of, fo	or congenital heart disease (Ar	naes.) (Assist.)	
38757	(See para TN.8.67 c Fee: \$2,134.50	f explanatory notes to this Categ Benefit: 75% = \$1600.90	ory)		
	EXTRACARDIA	C CONDUIT, replacement of	f, for congenital heart disease	(Anaes.) (Assist.)	
38760	(See para TN.8.67 c Fee: \$2,134.50	f explanatory notes to this Categ Benefit: 75% = \$1600.90	ory)		
	VENTRICULAR disease (Anaes.) (rentricular obstruction, right o	r left, for congenital heart	
38763	(See para TN.8.67 c Fee: \$2,134.50	f explanatory notes to this Categ Benefit: 75% = \$1600.90	gory)		
	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist			ase (Anaes.) (Assist.)	
38766	(See para TN.8.67 c Fee: \$2,134.50	f explanatory notes to this Categ Benefit: 75% = \$1600.90	gory)		
	MISCELLANEOUS PROCEDURES ON THE CHEST				
		/ITY, aspiration of, for diagnotem 38803 applies	ostic purposes, not being a ser	vice associated with a	
38800	Fee: \$38.50	Benefit: 75% = \$28.90 85	5% = \$32.75		
	THORACIC CAN diagnostic sample	-	apeutic drainage (paracentesis), with or without	
38803	Fee: \$76.90	Benefit: 75% = \$57.70 85	5% = \$65.40		
	INTERCOSTAL	DRAIN, insertion of, not invo	olving resection of rib (exclud	ing aftercare) (Anaes.)	
38806	Fee: \$133.55	Benefit: 75% = \$100.20 8	35% = \$113.55		
	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.)			section of rib (excluding	
38809	Fee: \$164.55	Benefit: 75% = \$123.45 8	35% = \$139.90		
	PERCUTANEOU	S NEEDLE BIOPSY of lung	(Anaes.)		
38812	Fee: \$209.15	Benefit: 75% = \$156.90 8	85% = \$177.80		
T8. SUF	RGICAL OPERATIO	ONS		7. NEUROSURGICA	
	Group T8. Surgio	al Operations			
		Subgro	oup 7. Neurosurgical		
		Cabgie			

T8. SUF	GICAL OPERAT	IONS 7. NEUROSURGICAL		
		GENERAL		
	LUMBAR PUN	CTURE (Anaes.)		
39000	Fee: \$75.30	Benefit: 75% = \$56.50 85% = \$64.05		
	CISTERNAL PU	JNCTURE (Anaes.)		
39003	Fee: \$85.65	Benefit: 75% = \$64.25 85% = \$72.85		
	VENTRICULAR	R PUNCTURE (not including burr-hole) (Anaes.)		
39006	Fee: \$159.40	Benefit: 75% = \$119.55 85% = \$135.50		
	SUBDURAL HA	EMORRHAGE, tap for, each tap (Anaes.)		
39009	Fee: \$59.35	Benefit: 75% = \$44.55		
		ngle, preparatory to ventricular puncture or for inspection purpose - not being a service item applies (Anaes.)		
39012	Fee: \$237.60	Benefit: 75% = \$178.20		
	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.)			
39013	(See para TN.8.4 o Fee: \$109.15	f explanatory notes to this Category) Benefit: $75\% = \$81.90$ $85\% = \$92.80$		
		R RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL NITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.)		
39015	(See para TN.8.4 o Fee: \$376.00	f explanatory notes to this Category) Benefit: 75% = \$282.00		
	CEREBROSPIN	AL FLUID reservoir, insertion of (Anaes.) (Assist.)		
39018	Fee: \$376.00	Benefit: 75% = \$282.00		
		PAIN RELIEF		
	INJECTION OF similar substance	PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or (Anaes.)		
39100	(See para TN.8.4 o Fee: \$237.60	f explanatory notes to this Category) Benefit: $75\% = 178.20 $85\% = 202.00		
	NEURECTOMY	, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.)		
39106	Fee: \$1,188.20	Benefit: 75% = \$891.15		
	TRIGEMINAL O	GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.)		
39109	Fee: \$443.70	Benefit: 75% = \$332.80 85% = \$377.15		
	CRANIAL NER	VE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.)		
39112	Fee: \$1,541.50	Benefit: 75% = \$1156.15		
39115	PERCUTANEO	US NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, sociated spinal, epidural or regional nerve block (payable once only in a 30 day period)		

T8. SUR	RGICAL OPERATIONS	7. NEUROSURGICAL
	(Anaes.)	
	(See para TN.8.4 of explanatory notes to this Category) Fee: \$75.30 Benefit: 75% = \$56.50 85% = \$64.05	
	PERCUTANEOUS NEUROTOMY for facet joint denervation using radiological imaging control (Anaes.) (Assist.)	by radio-frequency probe or cryoprobe
39118	(See para TN.8.4 of explanatory notes to this Category) Fee: \$297.85 Benefit: 75% = \$223.40 85% = \$253.20	
	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)	
39121	(See para TN.8.4 of explanatory notes to this Category) Fee: \$631.75 Benefit: 75% = \$473.85 85% = \$550.05	
	CORDOTOMY OR MYELOTOMY, partial or total laminector zone (Drez) lesion (Anaes.) (Assist.)	omy for, or operation for dorsal root entry
39124	Fee: \$1,616.80 Benefit: 75% = \$1212.60	
	Intrathecal or epidural SPINAL CATHETER insertion or repla subcutaneous implanted infusion pump, for the management of (Assist.)	
39125	Fee: \$298.05 Benefit: 75% = \$223.55	
	INFUSION PUMP, subcutaneous implantation or replacement intrathecal or epidural catheter, and filling of reservoir with a t without programming the pump, for the management of chroni	herapeutic agent or agents, with or
39126	Fee: \$361.90 Benefit: 75% = \$271.45	
	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER chronic intractable pain (Anaes.)	R, insertion of, for the management of
39127	(See para TN.8.4 of explanatory notes to this Category) Fee: \$473.65 Benefit: 75% = \$355.25	
	INFUSION PUMP, subcutaneous implantation of, AND intrati insertion of, and connection of pump to catheter, and filling of agents, with or without programming the pump, for the manage (Assist.)	reservoir with a therapeutic agent or
39128	Fee: \$659.95 Benefit: 75% = \$495.00	
	EPIDURAL LEAD, percutaneous placement of, including intra management of chronic intractable neuropathic pain or pain fro maximum of 4 leads (Anaes.)	
39130	(See para TN.8.4 of explanatory notes to this Category) Fee: \$674.15 Benefit: 75% = \$505.65	
	ELECTRODES, epidural or peripheral nerve, management of of neurostimulator by a medical practitioner, for the management or pain from refractory angina pectoris - each day	
39131	Fee: \$127.80 Benefit: 75% = \$95.85 85% = \$108.65	
	Removal of subcutaneously IMPLANTED INFUSION PUMP intrathecal or epidural SPINAL CATHETER, for the managem	

T8. SUF	GICAL OPERATIONS	7. NEUROSURGICAL	
	(See para TN.8.4 of explanatory notes to this Category) Fee: \$159.40 Benefit: 75% = \$119.55		
	NEUROSTIMULATOR or RECEIVER, subcutaneous placem connection of extension wires to epidural or peripheral nerve e intractable neuropathic pain or pain from refractory angina per	electrodes, for the management of chronic	
39134	Fee: \$340.60 Benefit: 75% = \$255.45		
	NEUROSTIMULATOR or RECEIVER, that was inserted for neuropathic pain or pain from refractory angina pectoris, remo of a hospital (Anaes.)	6	
39135	Fee: \$159.40 Benefit: 75% = \$119.55		
	LEAD, epidural or peripheral nerve that was inserted for the n neuropathic pain or pain from refractory angina pectoris, remo of a hospital (Anaes.)		
39136	(See para TN.8.4 of explanatory notes to this Category) Fee: \$159.40 Benefit: 75% = \$119.55		
	LEAD, epidural or peripheral nerve that was inserted for the n neuropathic pain or pain from refractory angina pectoris, surgi or unsatisfactory positioning, including intraoperative test stim 39130, 39138 or 39139 applies (Anaes.)	cal repositioning to correct displacement	
39137	Fee: \$605.35 Benefit: 75% = \$454.05		
	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.)		
39138	Fee: \$674.15 Benefit: 75% = \$505.65		
	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.)		
39139	Fee: \$905.10 Benefit: 75% = \$678.85		
	EPIDURAL CATHETER, insertion of, under imaging control therapeutic injection for lysis of adhesions (Anaes.)	, with epidurogram and epidural	
39140	Fee: \$292.85 Benefit: 75% = \$219.65 85% = \$248.95		
	PERIPHERAL NERVE	ES	
	CUTANEOUS NERVE (including digital nerve), primary repaired (Anaes.) (Assist.)	air of, using microsurgical techniques	
39300	Fee: \$353.35 Benefit: 75% = \$265.05		
	CUTANEOUS NERVE (including digital nerve), secondary re (Anaes.) (Assist.)	epair of, using microsurgical techniques	
39303	Fee: \$466.10 Benefit: 75% = \$349.60		
	NERVE TRUNK, primary repair of, using microsurgical techn	niques (Anaes.) (Assist.)	
39306	Fee: \$676.80 Benefit: 75% = \$507.60		

T8. SUF	GICAL OPERATIO	NS		7. NEUROSURGICAL
	NERVE TRUNK, secondary repair of, using		microsurgical techniques (Anae	es.) (Assist.)
39309	Fee: \$714.35	Benefit: 75% = \$535.80		
	NERVE TRUNK,	(interfascicular), neurolys	is of, using microsurgical techni	ques (Anaes.) (Assist.)
39312	Fee: \$398.55	Benefit: 75% = \$298.95		
	NERVE TRUNK, techniques (Anaes.		t) including harvesting of nerve	graft using microsurgical
39315	Fee: \$1,030.20	Benefit: 75% = \$772.65		
	CUTANEOUS NE (Anaes.) (Assist.)	RVE (including digital ne	erve), nerve graft to, using micro	surgical techniques
39318	Fee: \$639.20	Benefit: 75% = \$479.40		
	NERVE, transposit	ion of (Anaes.) (Assist.)		
39321	Fee: \$473.65	Benefit: 75% = \$355.25		
		NEUROTOMY by cryotother item applies (Anaes	therapy or radiofrequency lesion s.) (Assist.)	a generator, not being a
39323	Fee: \$276.80	Benefit: 75% = \$207.60	85% = \$235.30	
	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.)			
39324	(See para TN.8.4 of e Fee: \$276.80	Explanatory notes to this Cate Benefit: 75% = \$207.60		
			al of tumour from deep peripher: 41575, 41576, 41578 or 41579 a	
39327	(See para TN.8.4 of e Fee: \$473.75	Explanatory notes to this Cate Benefit: 75% = \$355.35	egory)	
		open operation without trapplies (Anaes.) (Assist.)	ansposition, not being a service	associated with a service to
39330	Fee: \$276.80	Benefit: 75% = \$207.60		
	CARPAL TUNNE	L RELEASE (division of	transverse carpal ligament), by a	any method (Anaes.)
39331	Fee: \$276.80	Benefit: 75% = \$207.60	85% = \$235.30	
	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.)			tem in this Group applies
39333	Fee: \$398.55	Benefit: 75% = \$298.95	85% = \$338.80	
	CRANIAL NERVES			
	VESTIBULAR NE	RVE, section of, via post	erior fossa (Anaes.) (Assist.)	
39500	Fee: \$1,270.90	Benefit: 75% = \$953.20		
	FACIO-HYPOGLO	DSSAL nerve or FACIO-	ACCESSORY nerve, anastomos	is of (Anaes.) (Assist.)
39503	Fee: \$955.00	Benefit: 75% = \$716.25		
		CRANIC	O-CEREBRAL INJURIES	

T8. SUF	RGICAL OPERATI	ONS	7. NEUROSURGICAL	
	INTRACRANIA (Assist.)	L HAEMORRHAGE, burr-hole cr	raniotomy for - including burr-holes (Anaes.)	
39600	Fee: \$473.65	Benefit: 75% = \$355.25		
	INTRACRANIA of haematoma (A	-	c craniotomy or extensive craniectomy and removal	
39603	Fee: \$1,195.70	Benefit: 75% = \$896.80		
	FRACTURED S	KULL, depressed or comminuted,	operation for (Anaes.) (Assist.)	
39606	Fee: \$797.10	Benefit: 75% = \$597.85		
	FRACTURED S	KULL, compound, without dural p	penetration, operation for (Anaes.) (Assist.)	
39609	Fee: \$955.00	Benefit: 75% = \$716.25		
		KULL, compound, depressed or co ion for (Anaes.) (Assist.)	omplicated, with dural penetration and brain	
39612	Fee: \$1,120.45	Benefit: 75% = \$840.35		
	FRACTURED SI (Anaes.) (Assist.)		ea, repair of by cranioplasty or endoscopic approach	
39615	Fee: \$1,195.70	Benefit: 75% = \$896.80		
		SKULL BAS	SE SURGERY	
	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.)			
39640	(See para TN.8.70 Fee: \$3,031.65	of explanatory notes to this Category) Benefit: 75% = \$2273.75		
	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.)			
39642	(See para TN.8.70 Fee: \$3,187.25	of explanatory notes to this Category) Benefit: 75% = \$2390.45		
	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.)			
39646	(See para TN.8.70 Fee: \$3,653.60	of explanatory notes to this Category) Benefit: 75% = \$2740.20		
	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.)			
39650	(See para TN.8.70 Fee: \$2,642.95	of explanatory notes to this Category) Benefit: 75% = \$1982.25		
		al radical excision (intracranial pro	val of, by supra and infratentorial approaches for occedure), not being a service to which item 39654 or	
39653	(See para TN.8.70 Fee: \$4,703.15	of explanatory notes to this Category) Benefit: 75% = \$3527.40		

T8. SUF	GICAL OPERATIONS	7. NEUROSURGICAL
	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra an radical or sub-total radical excision, (intracranial procedure), conjoint (Anaes.) (Assist.)	
39654	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,420.50 Benefit: 75% = \$2565.40	
	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra an radical or sub-total radical excision, (intracranial procedure) conjoint	
39656	(See para TN.8.70 of explanatory notes to this Category) Fee: \$2,565.30 Benefit: 75% = \$1924.00	
	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical e transmaxillary approach (Anaes.) (Assist.)	excision of, involving transoral or
39658	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,031.65 Benefit: 75% = \$2273.75	
	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, ra craniotomy with or without intracranial carotid artery exposure (Anae	
39660	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,031.65 Benefit: 75% = \$2273.75	
	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, 1 transcondylar or far lateral suboccipital approach (Anaes.) (Assist.)	adical excision of, via
39662	(See para TN.8.70 of explanatory notes to this Category) Fee: \$3,031.65 Benefit: 75% = \$2273.75	
	INTRA-CRANIAL NEOPLASMS	
	SKULL TUMOUR, benign or malignant, excision of, excluding cran	ioplasty (Anaes.) (Assist.)
39700	Fee: \$556.60 Benefit: 75% = \$417.45	
	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and ba (Anaes.) (Assist.)	iopsy of, or drainage of, or both
39703	Fee: \$519.00 Benefit: 75% = \$389.25	
	INTRACRANIAL tumour, biopsy or decompression of via osteoplast decompression of via osteoplastic flap (Anaes.) (Assist.)	tic flap OR biopsy and
39706	Fee: \$1,112.85 Benefit: 75% = \$834.65	
	CRANIOTOMY for removal of glioma, metastatic carcinoma or any cerebellum or brain stem - not being a service to which another item i (Assist.)	
39709	Fee: \$1,586.75 Benefit: 75% = \$1190.10	
	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, intraventricular tumour or any other intracranial tumour, not being a s Sub-group applies (Anaes.) (Assist.)	
39712	Fee: \$2,865.00 Benefit: 75% = \$2148.75	
	PITUITARY TUMOUR, removal of, by transcranial or transphenoid	al approach (Anaes.) (Assist.)
39715	Fee: \$1,985.30 Benefit: 75% = \$1489.00	

T8. SUF	RGICAL OPERATI	ONS 7. NEUROSURGICAL
	ARACHNOIDAI	CYST, craniotomy for (Anaes.) (Assist.)
39718	Fee: \$872.30	Benefit: 75% = \$654.25
	CRANIOTOMY, etc (Anaes.) (Assi	involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, ist.)
39721	Fee: \$797.10	Benefit: 75% = \$597.85
		CEREBROVASCULAR DISEASE
	ANEURYSM, cli	pping or reinforcement of sac (Anaes.) (Assist.)
39800	Fee: \$2,857.55	Benefit: 75% = \$2143.20
	INTRACRANIA	L ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.)
39803	Fee: \$2,857.55	Benefit: 75% = \$2143.20
		arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.)
39806	Fee: \$1,285.75	Benefit: 75% = \$964.35
		L ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.)
39812	Fee: \$631.75	Benefit: 75% = \$473.85
	CAROTID-CAV (Anaes.) (Assist.)	ERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure
39815	Fee: \$1,827.25	Benefit: 75% = \$1370.45 85% = \$1745.55
	EXTRACRANIA	L TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.)
39818	Fee: \$1,827.25	Benefit: 75% = \$1370.45
	EXTRACRANIA	L TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.)
39821	Fee: \$2,169.75	Benefit: 75% = \$1627.35
		INFECTION
	INTRACRANIA	L INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.)
39900	Fee: \$519.00	Benefit: 75% = \$389.25
	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.)	
39903	Fee: \$1,586.75	Benefit: 75% = \$1190.10
		IS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.)
39906	Fee: \$797.10	Benefit: 75% = \$597.85
		CEREBROSPINAL FLUID CIRCULATION DISORDERS
	VENTRICULO-0	CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.)
40000	Fee: \$917.40	Benefit: 75% = \$688.05
		ISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.)
40003	Fee: \$917.40	Benefit: 75% = \$688.05
10005		T DIVERSION, insertion of (Anaes.) (Assist.)
40006		

T8. SUF	RGICAL OPERAT	ONS 7. NEUROSURGICA
	Fee: \$721.95	Benefit: 75% = \$541.50
	CRANIAL, CIST	TERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.)
40009	Fee: \$526.40	Benefit: 75% = \$394.80
	THIRD VENTR	CULOSTOMY (open or endoscopic) with or without endoscopic septum
	pellucidotomy (A	.naes.) (Assist.)
40012	Fee: \$1,030.20	Benefit: 75% = \$772.65
	SUBTEMPORA	L DECOMPRESSION (Anaes.) (Assist.)
40015	Fee: \$638.65	Benefit: 75% = \$479.00
	LUMBAR CERE	EBROSPINAL FLUID DRAIN, insertion of (Anaes.)
40018	Fee: \$159.40	Benefit: 75% = \$119.55 85% = \$135.50
10010		CONGENITAL DISORDERS
	MENINGOCEL	E, excision and closure of (Anaes.) (Assist.)
40100	Fee: \$691.75	Benefit: 75% = \$518.85
10100		GOCELE, excision and closure of, including skin flaps or Z plasty where performed
	(Anaes.) (Assist.)	
40103	Fee: \$1,015.25	Benefit: 75% = \$761.45
	ARNOLD-CHIA	RI MALFORMATION, decompression of (Anaes.) (Assist.)
40106	Fee: \$1,030.20	Benefit: 75% = \$772.65
		DELE, excision and closure of (Anaes.) (Assist.)
40109		
10107		
40112		
40112	Fee: \$1,428.75	Benefit: 75% = \$1071.60 OSIS, operation for - single suture (Anaes.) (Assist.)
40115	Fee: \$721.95	Benefit: 75% = \$541.50
	CRANIOSTENC	OSIS, operation for - more than 1 suture (Anaes.) (Assist.)
40118	Fee: \$955.00	Benefit: 75% = \$716.25
		SPINAL DISORDERS
	INTERVERTEB	RAL DISC OR DISCS, partial or total laminectomy for removal of (Anaes.) (Assist.)
40300	Fee: \$955.00	Benefit: 75% = \$716.25
	INTERVERTEB	RAL DISC OR DISCS, microsurgical partial or total discectomy of (Anaes.) (Assist.)
40301	Fee: \$958.00	Benefit: 75% = \$718.50
	RECURRENT D level (Anaes.) (A	ISC LESION OR SPINAL STENOSIS, or both, partial or total laminectomy for - 1 ssist.)
40303	Fee: \$1,090.35	Benefit: 75% = \$817.80
40306	SPINAL STENC	SIS, partial or total laminectomy for, involving more than 1 vertebral interspace (disc

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGICAL
	level) (Anaes.) (Assist.)
	Fee: \$1,436.30 Benefit: 75% = \$1077.25
	EEXTRADURAL TUMOUR OR ABSCESS, partial or total laminectomy for (Anaes.) (Assist.)
40309	Fee: \$1,090.35 Benefit: 75% = \$817.80
	INTRADURAL LESION, partial or total laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.)
40312	Fee: \$1,466.30 Benefit: 75% = \$1099.75
	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.)
40315	Fee: \$1,586.75 Benefit: 75% = \$1190.10
	ODONTOID screw fixation (Anaes.) (Assist.)
40316	Fee: \$2,079.75 Benefit: 75% = \$1559.85
	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, partial or total laminectomy and radical excision of (Anaes.) (Assist.)
40318	Fee: \$1,985.30 Benefit: 75% = \$1489.00
	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.)
40321	Fee: \$1,090.35 Benefit: 75% = \$817.80
	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (Anaes.) (Assist.)
40324	Fee: \$639.20 Benefit: 75% = \$479.40
	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare (Assist.)
40327	Fee: \$639.20 Benefit: 75% = \$479.40
	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.)
40330	Fee: \$955.00 Benefit: 75% = \$716.25
	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.)
40331	Fee: \$955.00 Benefit: 75% = \$716.25
	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.)
40332	Fee: \$1,558.30 Benefit: 75% = \$1168.75
	CERVICAL PARTIAL OR TOTAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.)
40333	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.)		
	Fee: \$1,053.90	Benefit: 75% = \$790.45	
		OMPRESSION of spinal cord with or without involvement of nerve roots, including ore than 1 level, by any approach, not being a service to which item 40330 applies	
40335	Fee: \$1,935.60	Benefit: 75% = \$1451.70	
	INTRADISCAL I	NJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes.) (Assist.)	
40336	(See para TN.8.71 c Fee: \$315.90	of explanatory notes to this Category) Benefit: 75% = \$236.95	
	HYDROMYELIA	A, plugging of obex for, with or without duroplasty (Anaes.) (Assist.)	
40339	Fee: \$1,586.75	Benefit: 75% = \$1190.10	
	HYDROMYELIA (Anaes.) (Assist.)	A, craniotomy and partial or total laminectomy for, with cavity packing and CSF shunt	
40342	Fee: \$1,466.30	Benefit: 75% = \$1099.75	
		COMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle actomy (Anaes.) (Assist.)	
40345	Fee: \$1,365.00	Benefit: 75% = \$1023.75	
	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.)		
40348	Fee: \$1,733.10	Benefit: 75% = \$1299.85	
	THORACO-LUM procedure (Anaes	IBAR or high lumbar anterior decompression of spinal cord, not including stabilisation .) (Assist.)	
40351	Fee: \$1,733.10	Benefit: 75% = \$1299.85	
	SKULL RECONSTRUCTION		
	CRANIOPLAST	Y, reconstructive (Anaes.) (Assist.)	
40600	Fee: \$955.00	Benefit: 75% = \$716.25	
		EPILEPSY	
	CORPUS CALLO	OSUM, anterior section of, for epilepsy (Anaes.) (Assist.)	
40700	Fee: \$1,744.65	Benefit: 75% = \$1308.50	
	Vagus nerve stimu electrical pulse ge	ulation therapy through stimulation of the left vagus nerve, subcutaneous placement of nerator, for:	
	(a) management of refractory generalised epilepsy; or		
	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)		
40701	Fee: \$340.60	Benefit: 75% = \$255.45	
40702		ulation therapy through stimulation of the left vagus nerve, surgical repositioning or cal pulse generator inserted for:	

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL	
	(a) management of refractory generalise	d epilepsy; or	
	(b) treatment of refractory focal epilepsy	not suitable for resective epilepsy surgery (Anaes.) (Assist.)	
	Fee: \$159.40 Benefit: 75% = \$11	9.55	
	CORTICECTOMY, TOPECTOMY or I	PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.)	
40703	Fee: \$1,466.30 Benefit: 75% = \$10	99.75	
		a stimulation of the left vagus nerve, surgical placement of lead, s nerve and intra-operative test stimulation, for:	
	(a) management of refractory generalise	d epilepsy; or	
	(b) treatment of refractory focal epilepsy	not suitable for resective epilepsy surgery (Anaes.) (Assist.)	
40704	Fee: \$674.15 Benefit: 75% = \$50	5.65	
	Vagus nerve stimulation therapy through removal of lead attached to left vagus ne	a stimulation of the left vagus nerve, surgical repositioning or rve for:	
	(a) management of refractory generalise	d epilepsy; or	
	(b) treatment of refractory focal epilepsy	not suitable for resective epilepsy surgery (Anaes.) (Assist.)	
40705	Fee: \$605.35 Benefit: 75% = \$45	4.05	
	HEMISPHERECTOMY for intractable	epilepsy (Anaes.) (Assist.)	
40706	Fee: \$2,143.10 Benefit: 75% = \$16	07.35 85% = \$2061.40	
		a stimulation of the left vagus nerve, electrical analysis and a therapy device using external wand, for:	
	(a) management of refractory generalise	d epilepsy; or	
	(b) treatment of refractory focal epilepsy	not suitable for resective epilepsy surgery	
40707	Fee: \$189.70 Benefit: 75% = \$14	2.30 85% = \$161.25	
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical replacement of battery in electrical pulse generator inserted for:		
	(a) management of refractory generalised epilepsy; or		
	(b) treating refractory focal epilepsy not	suitable for resective epilepsy surgery (Anaes.) (Assist.)	
40708	Fee: \$340.60 Benefit: 75% = \$25	5.45	
	BURR-HOLE PLACEMENT of intracra	nial depth or surface electrodes (Anaes.) (Assist.)	
40709	Fee: \$519.00 Benefit: 75% = \$38	9.25	
	INTRACRANIAL ELECTRODE PLAC	CEMENT via craniotomy (Anaes.) (Assist.)	
40712	Fee: \$1,045.20 Benefit: 75% = \$78	3.90	
	ete		
	SIE	REOTACTIC PROCEDURES	
		REOTACTIC PROCEDURES CALISATION, as an independent procedure (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL
	FUNCTIONAL STEREOTACTIC procedure including computer physiological localisation, and lesion production in the basal gang tracts, not being a service associated with deep brain stimulation f or dystonia (Anaes.) (Assist.)	lia, brain stem or deep white matter
40801	Fee: \$1,745.80 Benefit: 75% = \$1309.35	
	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY Mitem 40800 or 40801 applies (Anaes.) (Assist.)	ETHOD, not being a service to which
40803	Fee: \$1,195.70 Benefit: 75% = \$896.80 85% = \$1114.00	
	DEEP BRAIN STIMULATION (unilateral) functional stereotacti assisted anatomical localisation, physiological localisation includi craniectomy and insertion of electrodes for the treatment of:	
	Parkinson's disease where the patient's response to medical therap by unacceptable motor fluctuations; or	y is not sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause s	severe disability (Anaes.) (Assist.)
40850	Fee: \$2,264.45 Benefit: 75% = \$1698.35	
	DEEP BRAIN STIMULATION (bilateral) functional stereotactic anatomical localisation, physiological localisation including twist craniectomy and insertion of electrodes for the treatment of:	
	Parkinson's disease where the patient's response to medical therap by unacceptable motor fluctuations; or	by is not sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause s	severe disability. (Anaes.) (Assist.)
40851	Fee: \$3,963.00 Benefit: 75% = \$2972.25	
	DEEP BRAIN STIMULATION (unilateral) subcutaneous placem pulse generator for the treatment of:	ent of neurostimulator receiver or
	Parkinson's disease where the patient's response to medical therap by unacceptable motor fluctuations; or	y is not sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause s	severe disability. (Anaes.) (Assist.)
40852	Fee: \$340.60 Benefit: 75% = \$255.45	
	DEEP BRAIN STIMULATION (unilateral) revision or removal of	of brain electrode for the treatment of:
40854	Parkinson's disease where the patient's response to medical therap by unacceptable motor fluctuations; or	by is not sustained and is accompanied

T8. SUF	GICAL OPERATIONS	7. NEUROSURGICAL	
	Essential tremor or dystonia where the patient's symptoms	s cause severe disability. (Anaes.)	
	Fee: \$526.40 Benefit: 75% = \$394.80		
	DEEP BRAIN STIMULATION (unilateral) removal or re generator for the treatment of:	placement of neurostimulator receiver or pulse	
	Parkinson's disease where the patient's response to medica by unacceptable motor fluctuations; or	al therapy is not sustained and is accompanied	
	Essential tremor or dystonia where the patient's symptoms	s cause severe disability. (Anaes.)	
40856	Fee: \$255.45 Benefit: 75% = \$191.60		
	DEEP BRAIN STIMULATION (unilateral) placement, re the treatment of:	emoval or replacement of extension lead for	
	Parkinson's disease where the patient's response to medica by unacceptable motor fluctuations; or	al therapy is not sustained and is accompanied	
	Essential tremor or dystonia where the patient's symptoms	s cause severe disability. (Anaes.)	
40858	Fee: \$526.40 Benefit: 75% = \$394.80		
	DEEP BRAIN STIMULATION (unilateral) target localisa physiological techniques, including intra-operative clinica neurostimulation wire for the treatment of:		
	Parkinson's disease where the patient's response to medica by unacceptable motor fluctuations; or	al therapy is not sustained and is accompanied	
	Essential tremor or dystonia where the patient's symptoms	s cause severe disability. (Anaes.)	
40860	Fee: \$2,022.70 Benefit: 75% = \$1517.05		
	DEEP BRAIN STIMULATION (unilateral) electronic and pulse generator for the treatment of:	alysis and programming of neurostimulator	
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or		
	Essential tremor or dystonia where the patient's symptoms	s cause severe disability. (Anaes.)	
40862	Fee: \$189.70 Benefit: 75% = \$142.30 85% = \$161.	25	
	MISCELLANEC	DUS	
_	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy incl burr hole (Anaes.) (Assist.)		
40903	Fee: \$554.55 Benefit: 75% = \$415.95		
	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the corre		
	of craniofacial abnormalities (Anaes.)	(67, 45776, 45782 and 45785 for the correction	

T8. SUF	RGICAL OPERATIONS 8. EAR, NOSE AND THROAT
	Group T8. Surgical Operations
	Subgroup 8. Ear, Nose And Throat
	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)
41500	(See para TN.8.72 of explanatory notes to this Category)Fee: $\$82.50$ Benefit: $75\% = \$61.90$ $85\% = \$70.15$
	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.)
41503	Fee: \$238.80 Benefit: 75% = \$179.10 85% = \$203.00
	AURAL POLYP, removal of (Anaes.)
41506	Fee: \$144.00 Benefit: 75% = \$108.00 85% = \$122.40
	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.)
41509	Fee: \$162.95 Benefit: 75% = \$122.25 85% = \$138.55
	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.)
41512	Fee: \$585.90 Benefit: 75% = \$439.45
	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.)
41515	(See para TN.8.73 of explanatory notes to this Category) Fee: \$384.55 Benefit: 75% = \$288.45
	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)
41518	Fee: \$928.75 Benefit: 75% = \$696.60
	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.)
41521	Fee: \$988.85 Benefit: 75% = \$741.65
	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.)
41524	(See para TN.8.74 of explanatory notes to this Category) Fee: \$285.70 Benefit: 75% = \$214.30
	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.)
41527	Fee: \$587.60 Benefit: 75% = \$440.70
	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.)
41530	Fee: \$957.30 Benefit: 75% = \$718.00
_	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)
41533	Fee: \$1,144.30 Benefit: 75% = \$858.25
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.

T8. SUF	RGICAL OPERATIONS		8. EAR, NOSE AND THROAT	
	Fee: \$1,281.70	Benefit: 75% = \$961.30		
	OSSICULAR CH	AIN RECONSTRUCTION (Ana	es.) (Assist.)	
41539	Fee: \$1,089.90	Benefit: 75% = \$817.45		
	OSSICULAR CH	AIN RECONSTRUCTION AND	MYRINGOPLASTY (Anaes.) (Assist.)	
41542	Fee: \$1,194.25	Benefit: 75% = \$895.70		
-13-2		MY (CORTICAL) (Anaes.) (Ass	st.)	
41545		Benefit: 75% = \$390.95		
41545	Fee: \$521.25	V OF THE MASTOID CAVITY ($\Delta naes) (\Delta ssist)$	
		·	miaes.) (Assist.)	
41548	Fee: \$691.75	Benefit: 75% = \$518.85		
	MASTOIDECTC	MY, intact wall technique, with r	nyringoplasty (Anaes.) (Assist.)	
41551	Fee: \$1,593.05	Benefit: 75% = \$1194.80		
	MASTOIDECTC (Anaes.) (Assist.)	MY, intact wall technique, with r	nyringoplasty and ossicular chain reconstruction	
41554	Fee: \$1,876.95	Benefit: 75% = \$1407.75		
	MASTOIDECTC	MY (RADICAL OR MODIFIED	RADICAL) (Anaes.) (Assist.)	
41557	Fee: \$1,089.90	Benefit: 75% = \$817.45		
	MASTOIDECTC	MY (RADICAL OR MODIFIED	RADICAL) AND MYRINGOPLASTY (Anaes.)	
41560	Fee: \$1,194.25	Benefit: 75% = \$895.70		
	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.)			
41563	Fee: \$1,478.40	Benefit: 75% = \$1108.80		
	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTO CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.)			
41564	Fee: \$1,911.80	Benefit: 75% = \$1433.85		
			lified radical or intact wall), including myringoplasty	
41566	Fee: \$1,089.90	Benefit: 75% = \$817.45		
		ON OF FACIAL NERVE in its m	astoid portion (Anaes.) (Assist.)	
41569	Fee: \$1,194.25	Benefit: 75% = \$895.70	-	
11507	· · · · · · · · · · · · · · · · · · ·	OMY OR DESTRUCTION OF L	ABYRINTH (Anaes.) (Assist.)	
41570				
41572	Fee: \$1,033.20	Benefit: 75% = \$774.90	noval of by 2 surgeons operating conjunity by	
	transmastoid, tran		noval of by 2 surgeons operating conjointly, by roach transmastoid, translabyrinthine or retromastoid	
41575	Fee: \$2,435.70	Benefit: 75% = \$1826.80		

T8. SUF	GICAL OPERATI	ONS 8. EAR, NOSE AND TH	IROAT	
	retromastoid appr	PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or oach - intracranial procedure (including aftercare) not being a service to which i pplies (Anaes.) (Assist.)		
41576	Fee: \$3,653.60	Benefit: 75% = \$2740.20		
		ONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or roach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (As	sist.)	
41578	Fee: \$2,435.70	Benefit: 75% = \$1826.80		
		ONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or roach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.)		
41579	Fee: \$1,826.75	Benefit: 75% = \$1370.10		
	TUMOUR INVC excision of (Anae	LVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and ras.) (Assist.)	adical	
41581	Fee: \$2,801.55	Benefit: 75% = \$2101.20		
		PORAL BONE RESECTION for removal of tumour involving mastoidectomy wession of facial nerve (Anaes.) (Assist.)	vith or	
41584	Fee: \$1,922.65	Benefit: 75% = \$1442.00		
	TOTAL TEMPO	RAL BONE RESECTION for removal of tumour (Anaes.) (Assist.)		
41587	Fee: \$2,618.60	Benefit: 75% = \$1963.95		
	ENDOLYMPHA (Anaes.) (Assist.)	TIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of		
41590	Fee: \$1,194.25	Benefit: 75% = \$895.70		
	TRANSLABYRI	NTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.)		
41593	Fee: \$1,556.50	Benefit: 75% = \$1167.40		
	. ,	NTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTIO)N, or	
41596	Fee: \$1,739.50	Benefit: 75% = \$1304.65		
	INTERNAL AUI decompression (A	DITORY MEATUS, exploration by middle cranial fossa approach with cranial n Anaes.) (Assist.)	erve	
41599	Fee: \$1,739.50	Benefit: 75% = \$1304.65		
	OSSEO-INTEGRATION PROCEDURE - implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients:			
	- With a perma	nent or long term hearing loss; and		
	- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons and			
		nduction thresholds that accord to recognised criteria for the implantable bone ng device being inserted.		
41603	Not being a servi	ce associated with a service to which items 41554, 45794 or 45797 (Anaes.)		

T8. SUF	RGICAL OPERATIONS		8. EAR, NOSE AND THROAT	
	Fee: \$503.85	Benefit: 75% = \$377.90) 85% = \$428.30	
			fixation of transcutaneous abutment implantation of titanium ction hearing system device, in patients:	
	- With a perma	ment or long term hearing l	oss; and	
	- Unable to utiliand	lise conventional air or bor	e conduction hearing aid for medical or audiological reasons;	
		nduction thresholds that ac ng device being inserted.	cord to recognised criteria for the implantable bone	
	Not being a servi	ice associated with a servic	e to which items 41554, 45794 or 45797 (Anaes.)	
41604	Fee: \$186.50	Benefit: 75% = \$139.90	0 85% = \$158.55	
	STAPEDECTON	MY (Anaes.) (Assist.)		
41608	Fee: \$1,089.90	Benefit: 75% = \$817.45	5	
	STAPES MOBII	LISATION (Anaes.) (Assis	t.)	
41611	Fee: \$701.30	Benefit: 75% = \$526.00)	
	ROUND WIND	OW SURGERY including	repair of cochleotomy (Anaes.) (Assist.)	
41614	Fee: \$1,089.90	Benefit: 75% = \$817.45	5 85% = \$1008.20	
		W SURGERY, including re er item in this Group applie	epair of fistula, not being a service associated with a service es (Anaes.) (Assist.)	
41615	Fee: \$1,089.90	Benefit: 75% = \$817.45	5 85% = \$1008.20	
	COCHLEAR IM	IPLANT, insertion of, inclu	iding mastoidectomy (Anaes.) (Assist.)	
41617	Fee: \$1,895.20	Benefit: 75% = \$1421.4	10	
	Middle ear impla	ant, partially implantable, in	sertion of, via mastoidectomy, for patients with:	
	(a) stable sensorineural hearing loss; and			
	(b) outer ear pathology that prevents the use of a conventional hearing aid; and			
	(c) a PTA4 of less than 80 dBHL; and			
	(d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) of each other; and			
	(e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and			
	(f) a normal middle ear; and			
	(g) normal tympanometry; and			
	(h) on audiometry, an air-bone gap of less than 10 dBHL (0.5-4kHz) across all frequencies; and			
41618	(i) no other inner	ear disorders		

T8. SUF	RGICAL OPERATIO	NS 8. EAR, NOSE AND THROAT
	(Anaes.) (Assist.)	
	Fee: \$1,876.95	Benefit: 75% = \$1407.75
	GLOMUS TUMOU	JR, transtympanic removal of (Anaes.) (Assist.)
41620	Fee: \$824.55	Benefit: 75% = \$618.45
	GLOMUS TUMOU	JR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.)
41623	Fee: \$1,194.25	Benefit: 75% = \$895.70
	ABSCESS OR INF	LAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.)
41626	(See para TN.8.4 of e Fee: \$144.00	seplanatory notes to this Category)Benefit: 75% = \$108.0085% = \$122.40
	MIDDLE EAR, EX	PLORATION OF (Anaes.) (Assist.)
41629	Fee: \$521.25	Benefit: 75% = \$390.95
	MIDDLE EAR, ins	ertion of tube for DRAINAGE OF (including myringotomy) (Anaes.)
41632	Fee: \$238.80	Benefit: 75% = \$179.10 85% = \$203.00
		MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, ingoplasty (Anaes.) (Assist.)
41635	Fee: \$1,144.30	Benefit: 75% = \$858.25 85% = \$1062.60
		MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, ingoplasty with ossicular chain reconstruction (Anaes.) (Assist.)
41638	Fee: \$1,428.35	Benefit: 75% = \$1071.30
	PERFORATION O	F TYMPANUM, cauterisation or diathermy of (Anaes.)
41641	Fee: \$47.45	Benefit: 75% = \$35.60 85% = \$40.35
	EXCISION OF RIM myringoplasty (Ana	A OF EARDRUM PERFORATION, not being a service associated with nes.)
41644	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40
		iring use of operating microscope and microinspection of tympanic membrane with naesthesia (Anaes.)
41647	Fee: \$109.90	Benefit: 75% = \$82.45 85% = \$93.45
	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.)	
41650	Fee: \$109.90	Benefit: 75% = \$82.45 85% = \$93.45
	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.)	
41653	Fee: \$71.95	Benefit: 75% = \$54.00 85% = \$61.20
		RHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without ith or without anterior pack (excluding aftercare) (Anaes.)
41656	(See para TN.8.4 of e	xplanatory notes to this Category)

T8. SUF	GICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	Fee: \$122.85	Benefit: 75% = \$92.15 85% = \$104.45
	NOSE, removal	of FOREIGN BODY IN, other than by simple probing (Anaes.)
41659	Fee: \$77.55	Benefit: 75% = \$58.20 85% = \$65.95
	NASAL POLYP	OR POLYPI (SIMPLE), removal of
	(See para TN.8.75	of explanatory notes to this Category)
41662	Fee: \$82.50	Benefit: 75% = \$61.90 85% = \$70.15
	NASAL POLYP	OR POLYPI, removal of (Anaes.)
		of explanatory notes to this Category)
41668	Fee: \$219.95	Benefit: 75% = \$165.00
	NASAL SEPTU (Anaes.)	M, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation
41671	Fee: \$483.25	Benefit: 75% = \$362.45
	NASAL SEPTU	M, reconstruction of (Anaes.) (Assist.)
41672	Fee: \$602.85	Benefit: 75% = \$452.15
	general anaesthe	her than by chemical means) or cauterisation by chemical means when performed under sia or diathermy of septum or turbinates—one or more of these procedures (including on the same occasion) other than a service associated with another operation on the
41674	Fee: \$100.50	Benefit: 75% = \$75.40 85% = \$85.45
	NASAL HAEM packing or both (ORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity (Anaes.)
41677	Fee: \$90.00	Benefit: 75% = \$67.50 85% = \$76.50
		ASAL ADHESIONS, with or without stenting not being a service associated with any on the nose and not performed during the postoperative period of a nasal operation
41683	Fee: \$117.20	Benefit: 75% = \$87.90 85% = \$99.65
		OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated which another item in this Group applies (Anaes.)
41686	Fee: \$71.95	Benefit: 75% = \$54.00 85% = \$61.20
	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.)	
41689	Fee: \$136.50	Benefit: 75% = \$102.40
	TURBINATES, submucous resection of, unilateral (Anaes.)	
41692	Fee: \$178.05	Benefit: 75% = \$133.55
.1072		ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.)
41/09		
41698	Fee: \$32.55	Benefit: 75% = \$24.45 85% = \$27.70
	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admissio to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.)	
41701		

T8. SUF	RGICAL OPERAT	IONS	8. EAR, NOSE AND THROAT	
	Fee: \$91.90	Benefit: 75% = \$68.95		
		ANTRUM, LAVAGE OF each attendance at sociated consultation (Anaes.)	which the procedure is performed,	
41704	Fee: \$36.30	Benefit: 75% = \$27.25 85% = \$30.90		
	MAXILLARY	ARTERY, transantral ligation of (Anaes.) (Ass	ist.)	
41707	Fee: \$448.55	Benefit: 75% = \$336.45		
	ANTROSTOM	Y (RADICAL) (Anaes.) (Assist.)		
41710	Fee: \$521.25	Benefit: 75% = \$390.95		
	ANTROSTOM (Anaes.) (Assist	Y (RADICAL) with transantral ethmoidectomy .)	y or transantral vidian neurectomy	
41713	Fee: \$606.50	Benefit: 75% = \$454.90		
	ANTRUM, intra	nasal operation on, or removal of foreign bod	y from (Anaes.) (Assist.)	
41716	Fee: \$295.70	Benefit: 75% = \$221.80		
	ANTRUM, drai	nage of, through tooth socket (Anaes.)		
41719	Fee: \$117.55	Benefit: 75% = \$88.20 85% = \$99.95		
	OROANTRAL	FISTULA, plastic closure of (Anaes.) (Assist.)		
41722	Fee: \$587.60	Benefit: 75% = \$440.70 85% = \$505.90		
	ETHMOIDAL A	ARTERY OR ARTERIES, transorbital ligation	n of (unilateral) (Anaes.) (Assist.)	
41725	Fee: \$448.55	Benefit: 75% = \$336.45		
	LATERAL RHI	NOTOMY with removal of tumour (Anaes.) (Assist.)	
41728	Fee: \$897.30	Benefit: 75% = \$673.00		
	DERMOID OF	NOSE, excision of, with intranasal extension (Anaes.) (Assist.)	
41729	Fee: \$568.65	Benefit: 75% = \$426.50		
	FRONTONASA (Assist.)	L ETHMOIDECTOMY by external approach	with or without sphenoidectomy (Anaes.)	
41731	Fee: \$777.10	Benefit: 75% = \$582.85		
	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)		lap (Anaes.) (Assist.)	
41734	Fee: \$1,014.05	Benefit: 75% = \$760.55		
	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.)		NE SIDE, intranasal operation on	
41737	Fee: \$483.25	Benefit: 75% = \$362.45		
	FRONTAL SIN	US, catheterisation of (Anaes.)		
41740	Fee: \$58.80	Benefit: 75% = \$44.10		
	FRONTAL SIN	US, trephine of (Anaes.) (Assist.)		
41743	Fee: \$337.45	Benefit: 75% = \$253.10		

T8. SUF	GICAL OPERAT	TIONS 8. EAR, NOSE AND THROAT
	FRONTAL SIN	US, radical obliteration of (Anaes.) (Assist.)
41746	Fee: \$777.10	Benefit: 75% = \$582.85 85% = \$695.40
	ETHMOIDAL S	SINUSES, external operation on (Anaes.) (Assist.)
41749	Fee: \$606.50	Benefit: 75% = \$454.90
	SPHENOIDAL	SINUS, intranasal operation on (Anaes.) (Assist.)
41752	Fee: \$295.70	Benefit: 75% = \$221.80
	EUSTACHIAN	TUBE, catheterisation of (Anaes.)
41755	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55
		PPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and or more of these procedures, unilateral or bilateral examination (Anaes.)
41764	Fee: \$122.85	Benefit: 75% = \$92.15 85% = \$104.45
	NASOPHARYN	NGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.)
41767	Fee: \$737.00	Benefit: 75% = \$552.75 85% = \$655.30
	PHARYNGEAI	POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)
41770	Fee: \$701.30	Benefit: 75% = \$526.00
	PHARYNGEAI	POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.)
41773	Fee: \$587.60	Benefit: 75% = \$440.70
	CRICOPHARY	NGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)
41776	Fee: \$585.90	Benefit: 75% = \$439.45
	PHARYNGOT	DMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)
41779	Fee: \$701.30	Benefit: 75% = \$526.00
	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)	
41782	Fee: \$952.10	Benefit: 75% = \$714.10 85% = \$870.40
	PARTIAL PHA (Assist.)	RYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.)
41785	Fee: \$1,181.15	Benefit: 75% = \$885.90
	UVULOPALAT (Assist.)	OPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.)
41786	Fee: \$737.00	Benefit: 75% = \$552.75
		Y AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, tonsillectomy, 1 or more stages, including any revision procedures within 12 months .)
41787	Fee: \$568.65	Benefit: 75% = \$426.50 85% = \$486.95
41789		s and adenoids, removal of, in a person aged less than 12 years (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	service to which	item 41764 applies
	(Anaes.)	
	Fee: \$295.70	Benefit: 75% = \$221.80
	examination of the	s and adenoids, removal of, in a person 12 years of age or over (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)
41793	Fee: \$371.50	Benefit: 75% = \$278.65
		ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general owing removal of (Anaes.)
41797	Fee: \$144.00	Benefit: 75% = \$108.00
		val of (including any examination of the postnasal space and nasopharynx and the cal anaesthetic), not being a service to which item 41764 applies (Anaes.)
41801	Fee: \$162.95	Benefit: 75% = \$122.25
	LINGUAL TON	SIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.)
41804	Fee: \$90.00	Benefit: 75% = \$67.50
	PERITONSILLA	AR ABSCESS (quinsy), incision of (Anaes.)
41807	Fee: \$70.10	Benefit: 75% = \$52.60 85% = \$59.60
	UVULOTOMY	or UVULECTOMY (Anaes.)
41810	Fee: \$35.60	Benefit: 75% = \$26.70 85% = \$30.30
	VALLECULAR	OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)
41813	Fee: \$356.35	Benefit: 75% = \$267.30
	OESOPHAGOS	COPY (with rigid oesophagoscope) (Anaes.)
41816	Fee: \$185.60	Benefit: 75% = \$139.20 85% = \$157.80
	OESOPHAGOS	COPY (with rigid oesophagoscope), with biopsy (Anaes.)
41822	Fee: \$238.80	Benefit: 75% = \$179.10
-		COPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.)
41825	Fee: \$356.35	Benefit: 75% = \$267.30
-		L STRICTURE, dilatation of, without oesophagoscopy (Anaes.)
41828	Fee: \$52.20	Benefit: 75% = \$39.15 85% = \$44.40
		loscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.)
41831	Fee: \$357.00	Benefit: 75% = \$267.75 85% = \$303.45
.1051		, balloon dilatation of, using interventional imaging techniques (Anaes.)
11830		
41832	Fee: \$228.50	Benefit: 75% = \$171.40 85% = \$194.25

T8. SUF	RGICAL OPERATI	ONS 8. EAR, NOSE AND THROAT		
	LARYNGECTO	MY (TOTAL) (Anaes.) (Assist.)		
41834	Fee: \$1,289.15	Benefit: 75% = \$966.90		
	VERTICAL HEN	AILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)		
41837	Fee: \$1,236.05	Benefit: 75% = \$927.05		
	SUPRAGLOTTI	C LARYNGECTOMY including tracheostomy (Anaes.) (Assist.)		
41840	Fee: \$1,519.80	Benefit: 75% = \$1139.85		
		RYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY yngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)		
41843	Fee: \$1,336.45	Benefit: 75% = \$1002.35		
		examination of the supraglottic, glottic and subglottic regions, not being a service ny other procedure on the larynx or with the administration of a general anaesthetic		
		of explanatory notes to this Category)		
41846	Fee: \$185.60	Benefit: 75% = \$139.20 85% = \$157.80 GOSCOPY (Anaes.) (Assist.)		
41055				
41855	Fee: \$288.20	Benefit: 75% = \$216.15 GOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.)		
41858	(See para 1N.8.77) Fee: \$494.15	of explanatory notes to this Category) Benefit: 75% = \$370.65		
	MICROLARYNO (Assist.)	GOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.)		
41861	Fee: \$604.30	Benefit: 75% = \$453.25		
	MICROLARYN	GOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)		
41864	Fee: \$407.50	Benefit: 75% = \$305.65		
	MICROLARYN	GOSCOPY with arytenoidectomy (Anaes.) (Assist.)		
41867	Fee: \$613.40	Benefit: 75% = \$460.05		
	LARYNGEAL W	VEB, division of, using microlarygoscopic techniques (Anaes.)		
41868	Fee: \$388.70	Benefit: 75% = \$291.55		
	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist			
41870 Fee: \$454.85 B		Benefit: 75% = \$341.15		
	LARYNX, FRACTURED, operation for (Anaes.) (Assist.)			
41873	Fee: \$587.60	Benefit: 75% = \$440.70 85% = \$505.90		
	LARYNX, extern (Assist.)	nal operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.)		
41876	Fee: \$587.60	Benefit: 75% = \$440.70 85% = \$505.90		
41879	LARYNGOPLA	STY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERATI	ONS 8. EAR, NOSE AND THROAT	
	Fee: \$952.10	Benefit: 75% = \$714.10	
		MY by a percutaneous technique using sequential dilatation or partial splitting method of a cuffed tracheostomy tube (Anaes.)	
41880	Fee: \$254.15	Benefit: 75% = \$190.65	
		MY by open exposure of the trachea, including separation of the strap muscles or yroid isthmus, where performed (Anaes.) (Assist.)	
41881	Fee: \$401.75	Benefit: 75% = \$301.35	
	CRICOTHYROS	TOMY by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.)	
41884	(See para TN.8.2 of Fee: \$91.05	f explanatory notes to this Category) Benefit: 75% = \$68.30	
		PHAGEAL FISTULA, formation of, as a secondary procedure following cluding associated endoscopic procedures (Anaes.) (Assist.)	
41885	Fee: \$287.90	Benefit: 75% = \$215.95 85% = \$244.75	
	TRACHEA, remo	oval of foreign body in (Anaes.)	
41886	Fee: \$178.05	Benefit: 75% = \$133.55 85% = \$151.35	
	BRONCHOSCO	PY, as an independent procedure (Anaes.)	
41889	Fee: \$178.05	Benefit: 75% = \$133.55 85% = \$151.35	
		PY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures	
41892	Fee: \$235.05	Benefit: 75% = \$176.30 85% = \$199.80	
	BRONCHUS, removal of foreign body in (Anaes.) (Assist.)		
41895	Fee: \$367.75	Benefit: 75% = \$275.85	
	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.)		
41898	Fee: \$256.95	Benefit: 75% = \$192.75 85% = \$218.45	
	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.)		
41901	Fee: \$604.30	Benefit: 75% = \$453.25	
	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.)		
41904 Fee: \$246.50 Benefit: 75% = \$184.90 85% = \$209.55		Benefit: 75% = \$184.90 85% = \$209.55	
	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assis		
41905	Fee: \$453.35	Benefit: 75% = \$340.05	
		M BUTTON, insertion of (Anaes.)	
41907	Fee: \$122.85	Benefit: 75% = \$92.15 85% = \$104.45	
41907		DR SALIVARY GLAND, transposition of (Anaes.) (Assist.)	
41910	Fee: \$390.25	Benefit: 75% = \$292.70	

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	Group T8. Surgi	cal Operations	
		Subgroup 9. Ophthal	mology
		OGICAL EXAMINATION under general a which another item in this Group applies (A	
42503	Fee: \$102.50	Benefit: 75% = \$76.90	
	EYE, ENUCLEA	ATION OF, with or without sphere implant	(Anaes.) (Assist.)
42506	Fee: \$481.25	Benefit: 75% = \$360.95 85% = \$409.10	
	EYE, ENUCLEA	ATION OF, with insertion of integrated imp	lant (Anaes.) (Assist.)
42509	Fee: \$609.05	Benefit: 75% = \$456.80	
	EYE, enucleation (Assist.)	n of, with insertion of hydroxy apatite impla	nt or similar coralline implant (Anaes.)
42510	Fee: \$702.05	Benefit: 75% = \$526.55	
	GLOBE, EVISC	ERATION OF (Anaes.) (Assist.)	
42512	Fee: \$481.25	Benefit: 75% = \$360.95 85% = \$409.10	
	GLOBE, EVISC (Anaes.) (Assist.)	ERATION OF, AND INSERTION OF INT)	RASCLERAL BALL OR CARTILAGE
42515	Fee: \$609.05	Benefit: 75% = \$456.80	
	procedure, or RE	IIC ORBIT, INSERTION OF CARTILAGE MOVAL OF IMPLANT FROM SOCKET, PEG by drilling into an existing orbital imp	
42518	Fee: \$353.35	Benefit: 75% = \$265.05	
		IIC SOCKET, treatment of, by insertion of a secondary procedure (Anaes.) (Assist.)	a wired-in conformer, integrated implant or
42521	Fee: \$1,203.20	Benefit: 75% = \$902.40	
	ORBIT, SKIN G	RAFT TO, as a delayed procedure (Anaes.)	
42524	Fee: \$204.60	Benefit: 75% = \$153.45 85% = \$173.95	
	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTI AND STENT MOULD (Anaes.) (Assist.)		DING MUCOUS MEMBRANE GRAFTING
42527	Fee: \$406.05	Benefit: 75% = \$304.55	
	ORBIT, EXPLO	RATION with or without biopsy, requiring	REMOVAL OF BONE (Anaes.) (Assist.)
42530	Fee: \$631.75	Benefit: 75% = \$473.85	
	ORBIT, EXPLO	RATION OF, with drainage or biopsy not r	equiring removal of bone (Anaes.) (Assist.)
42533	Fee: \$406.05	Benefit: 75% = \$304.55	
		ERATION OF, with or without skin graft a	nd with or without temporalis muscle
42536	Fee: \$834.60	Benefit: 75% = \$625.95	

T8. SUF	RGICAL OPERATIO	NS 9. OPHTHALMOLOGY
	ORBIT, EXPLORA (Anaes.) (Assist.)	ATION OF, with removal of tumour or foreign body, requiring removal of bone
42539	Fee: \$1,188.20	Benefit: 75% = \$891.15
	ORBIT, exploration	n of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.)
42542	Fee: \$503.85	Benefit: 75% = \$377.90
	ORBIT, exploratio	n of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.)
42543	Fee: \$883.85	Benefit: 75% = \$662.90
		ssion of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the bital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.)
42545	Fee: \$1,278.35	Benefit: 75% = \$958.80
	OPTIC NERVE M	ENINGES, incision of (Anaes.) (Assist.)
42548	Fee: \$759.40	Benefit: 75% = \$569.55
		ING WOUND OR RUPTURE OF, not involving intraocular structures repair cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.)
42551	Fee: \$631.75	Benefit: 75% = \$473.85 85% = \$550.05
	EYE, PENETRAT repair (Anaes.) (As	ING WOUND OR RUPTURE OF, with incarceration or prolapse of uveal tissue sist.)
42554	Fee: \$737.00	Benefit: 75% = \$552.75
	EYE, PENETRAT (Anaes.) (Assist.)	ING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair
42557	Fee: \$1,030.20	Benefit: 75% = \$772.65
	INTRAOCULAR I	FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.)
42563	Fee: \$519.00	Benefit: 75% = \$389.25 85% = \$441.15
	INTRAOCULAR I	FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.)
42569	Fee: \$1,030.20	Benefit: 75% = \$772.65
	ORBITAL ABSCESS OR CYST, drainage of (Anaes.)	
42572	Fee: \$117.35	Benefit: 75% = \$88.05 85% = \$99.75
	DERMOID, periorbital, excision of, on a person 10 years of age or over (Anaes.)	
42573	Fee: \$227.45	Benefit: 75% = \$170.60 85% = \$193.35
		l, excision of (Anaes.) (Assist.)
42574	Fee: \$483.25	Benefit: 75% = \$362.45 85% = \$410.80
		xtirpation of (Anaes.)
42575	Fee: \$82.75	Benefit: 75% = \$62.10 85% = \$70.35
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T8. SUF	GICAL OPERAT	IONS	9. OPHTHALMOLOGY
	DERMOID, periorbital, excision of, on a person under 10 years of age (Anaes.)		
42576	Fee: \$295.70	Benefit: 75% = \$221.80 85% = \$251.35	
	ECTROPION O	R ENTROPION, tarsal cauterisation of (Anaes	5.)
42581	Fee: \$117.35	Benefit: 75% = \$88.05 85% = \$99.75	
	TARSORRHAP	HY (Anaes.) (Assist.)	
42584	Fee: \$276.80	Benefit: 75% = \$207.60 85% = \$235.30	
	TRICHIASIS, tr	eatment of by cryotherapy, laser or electrolysis	s - each eyelid (Anaes.)
42587	Fee: \$51.95	Benefit: 75% = \$39.00 85% = \$44.20	
	CANTHOPLAS	TY, medial or lateral (Anaes.) (Assist.)	
	Fee: \$338.35	Benefit: 75% = \$253.80 85% = \$287.60	
42590		care Safety Net Cap: \$270.70	
	LACRIMAL GI	AND, excision of palpebral lobe (Anaes.)	
42593	Fee: \$204.60	Benefit: 75% = \$153.45	
	LACRIMAL SA	C, excision of, or operation on (Anaes.) (Assis	st.)
42596	Fee: \$503.85	Benefit: 75% = \$377.90 85% = \$428.30	
		NALICULAR SYSTEM, establishment of pat 1 eye (Anaes.) (Assist.)	tency by closed operation using silicone
42599	Fee: \$631.75	Benefit: 75% = \$473.85 85% = \$550.05	
	LACRIMAL CA (Assist.)	NALICULAR SYSTEM, establishment of part	tency by open operation, 1 eye (Anaes.)
42602	Fee: \$631.75	Benefit: 75% = \$473.85 85% = \$550.05	
	LACRIMAL CA	NALICULUS, immediate repair of (Anaes.) (Assist.)
42605	Fee: \$466.10	Benefit: 75% = \$349.60 85% = \$396.20	
	LACRIMAL DE	AINAGE by insertion of glass tube, as an inde	ependent procedure (Anaes.) (Assist.)
42608	Fee: \$300.75	Benefit: 75% = \$225.60 85% = \$255.65	
	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.)		
42610	Fee: \$96.25	Benefit: 75% = \$72.20 85% = \$81.85	
	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.)		
42611	Fee: \$144.35	Benefit: 75% = \$108.30 85% = \$122.70	
	probing to establ	AL TUBE (unilateral), removal or replacemen ish patency of the lacrimal passage and/or site g a service associated with a service to which it	of obstruction, unilateral, including
42614	(See para TN.8.4 o Fee: \$48.30	of explanatory notes to this Category) Benefit: 75% = \$36.25 85% = \$41.10	

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	to establish pate	ncy of the lacrimal passage an	l or replacement of, or LACRIMAL PASSAGES, probing d/or site of obstruction, bilateral, including lavage, not tich item 42611 applies (excluding aftercare)
42615	Fee: \$72.25	Benefit: 75% = \$54.20 8	5% = \$61.45
	PUNCTUM SN	IP operation (Anaes.)	
42617	Fee: \$136.95	Benefit: 75% = \$102.75	85% = \$116.45
	PUNCTUM, oc	clusion of, by use of a plug (A	naes.)
42620	Fee: \$52.65	Benefit: 75% = \$39.50 8	25% = \$44.80
	PUNCTUM, per	manent occlusion of, by use o	f electrical cautery (Anaes.)
42622	Fee: \$82.75	Benefit: 75% = \$62.10 8	5% = \$70.35
12022		CORHINOSTOMY (Anaes.) (A	
42623	Fee: \$699.45	Benefit: 75% = \$524.60	
42025		CORHINOSTOMY where a pr	revious dacryocystorhinostomy has been performed
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42626	<b>Fee:</b> \$1,128.05	<b>Benefit:</b> 75% = \$846.05	
	(Anaes.) (Assist	•	acryocystorhinostomy and fashioning of conjunctival flaps
42629	Fee: \$849.70	<b>Benefit:</b> 75% = \$637.30	
	CONJUNCTIVA (Anaes.)	AL PERITOMY OR REPAIR	OF CORNEAL LACERATION by conjunctival flap
42632	Fee: \$117.35	<b>Benefit:</b> 75% = \$88.05 8	5% = \$99.75
	CORNEAL PER	RFORATIONS, sealing of, wit	th tissue adhesive (Anaes.) (Assist.)
42635	Fee: \$300.75	<b>Benefit:</b> 75% = \$225.60	85% = \$255.65
	CONJUNCTIV	AL GRAFT OVER CORNEA	(Anaes.) (Assist.)
42638	Fee: \$376.00	<b>Benefit:</b> 75% = \$282.00	85% = \$319.60
			mucous membrane graft (Anaes.) (Assist.)
42641	<b>Fee:</b> \$488.75	<b>Benefit:</b> 75% = \$366.60	8506 - \$415.45
42041	CORNEA OR S		f embedded foreign body from - not more than once on the
42644		, TN.8.4 of explanatory notes to t Benefit: 75% = \$54.15 8	this Category)
	CORNEAL SCA		ratectomy, not being a service associated with a service to
42647	Fee: \$204.60	<b>Benefit:</b> 75% = \$153.45	85% = \$173.95
			ulcer or corneal erosion (excluding aftercare) (Anaes.)
	(See para TN.8.4)	of explanatory notes to this Categ	ory)
42650	<b>Fee:</b> \$72.15	<b>Benefit:</b> 75% = \$54.15 8	

T8. SUR		ONS	9. OPHTHALMOLOGY
	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.)		
42651	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% =	\$136.70
	Corneal collagen progression—per	• •	orneal ectatic disorder, with evidence of
<b>New</b> 42652 S	(See para TN.8.2, T <b>Fee:</b> \$1,200.00	N.8.136 of explanatory notes to this C <b>Benefit:</b> 75% = \$900.00 85% =	
	CORNEA transpl	antation of (Anaes.) (Assist.)	
42653	Fee: \$1,307.75	<b>Benefit:</b> 75% = \$980.85	
	CORNEA, transp	antation of, second and subsequen	t procedures (Anaes.) (Assist.)
42656	Fee: \$1,669.45	<b>Benefit:</b> 75% = \$1252.10	
	SCLERA, transpl	antation of, full thickness, includin	g collection of donor material (Anaes.) (Assist.)
42662	Fee: \$902.30	<b>Benefit:</b> 75% = \$676.75	
	SCLERA, transpl (Assist.)	antation of, superficial or lamellar,	including collection of donor material (Anaes.)
42665	Fee: \$601.65	<b>Benefit:</b> 75% = \$451.25 85% =	\$519.95
	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		
42667	Fee: \$141.95	<b>Benefit:</b> 75% = \$106.50 85% =	\$120.70
	CORNEAL SUTI		6 weeks after operation requiring use of slit lamp or
42668	Fee: \$75.30	<b>Benefit:</b> 75% = \$56.50 85% = \$	664.05
	CORNEAL INCISONS, to correct corneal astigmatism of more than $1^{1/2}$ dioptres following anter segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.)		
42672	(See para TN.8.79 c <b>Fee:</b> \$902.30	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$676.75 85% =	\$820.60
	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.)		
42673 <b>Fee:</b> \$451.10 <b>Benefit:</b> 75% = \$338.35 85% = \$383.45		\$383.45	
	CONJUNCTIVA, biopsy of, as an independent procedure		
42676	Fee: \$115.70	<b>Benefit:</b> 75% = \$86.80 85% = 5	\$98.35
		CAUTERY OF, INCLUDING TI s given including any associated co	REATMENT OF PANNUS each attendance at onsultation (Anaes.)
42677	Fee: \$60.95	<b>Benefit:</b> 75% = \$45.75 85% = \$	551.85
	CONJUNCTIVA	cryotherapy to, for melanotic lesi	ons or similar using CO ² or N ² 0 (Anaes.)
42680	Fee: \$300.75	<b>Benefit:</b> 75% = \$225.60 85% =	\$255.65

T8. SUR	GICAL OPERAT	TIONS	9. OPHTHALMOLOGY
	CONJUNCTIV. (Anaes.)	AL CYSTS, removal of, req	quiring admission to hospital or approved day-hospital facility
42683	Fee: \$120.35	<b>Benefit:</b> 75% = \$90.30	
	PTERYGIUM,	removal of (Anaes.)	
42686	Fee: \$273.65	<b>Benefit:</b> 75% = \$205.25	5 85% = \$232.65
	PINGUECULA	, removal of, not being a ser	rvice associated with the fitting of contact lenses (Anaes.)
42689	Fee: \$117.35	<b>Benefit:</b> 75% = \$88.05	85% = \$99.75
	LIMBIC TUMO	OUR, removal of, excluding	Pterygium (Anaes.) (Assist.)
42692	Fee: \$276.80	<b>Benefit:</b> 75% = \$207.60	0 85% = \$235.30
	LIMBIC TUMC (Assist.)	UR, excision of, requiring	keratectomy or sclerectomy, excluding Pterygium (Anaes.)
42695	Fee: \$451.10	<b>Benefit:</b> 75% = \$338.35	5 85% = \$383.45
			performed for the correction of refractive error <i>except for</i> <i>wing the removal of cataract in the first eye</i> (Anaes.)
42698	(See para TN.8.80 <b>Fee:</b> \$594.75	) of explanatory notes to this Ca <b>Benefit:</b> 75% = \$446.10	
			uding surgery performed for the correction of refractive n 3 dioptres following the removal of cataract in the first eye
42701	(See para TN.8.80 <b>Fee:</b> \$331.70	) of explanatory notes to this C Benefit: 75% = \$248.80	
	for the correctio		OF INTRAOCULAR LENS, excluding surgery performed for anisometropia greater than 3 dioptres following the
42702	Fee: \$760.65 Extended Medi	<b>Benefit:</b> 75% = \$570.50 icare Safety Net Cap: \$114	
		R LENS or IRIS PROSTHE (Anaes.) (Assist.)	ESIS insertion of, into the posterior chamber with fixation to
42703	Fee: \$572.05	<b>Benefit:</b> 75% = \$429.05	5 85% = \$490.35
		R LENS, REMOVAL or R a service to which item 427	EPOSITIONING of by open operation, not being a service (01 applies (Anaes.)
42704	Fee: \$466.10	<b>Benefit:</b> 75% = \$349.60	0 85% = \$396.20
	for the correctio removal of catar device or device	on of refractive error except a ract in the first eye, performe es, in a patient diagnosed with	OF INTRAOCULAR LENS, excluding surgery performed for anisometropia greater than 3 dioptres following the ned in association with insertion of a trans-trabecular drainage ith open angle glaucoma who is not adequately responsive to as intolerant of anti-glaucoma medication. (Anaes.)
42705 S	Fee: \$760.65	<b>Benefit:</b> 75% = \$570.50	0 85% = \$678.95
42707			nd REPLACEMENT with a different lens, excluding surgery rror except for anisometropia greater than 3 dioptres

T8. SUF	GICAL OPERATIONS			9. OPHTHALMOLOGY
	following the removal of	cataract in the first	t eye (Anaes.)	
	Fee: \$797.10 Bene	efit: 75% = \$597.85	85% = \$715.40	
	INTRAOCULAR LENS, and fixated to the iris or so		placement with a lens inserted in sist.)	to the posterior chamber
42710	Fee: \$902.30 Bend	efit: 75% = \$676.75	85% = \$820.60	
	IRIS SUTURING, McCar (Anaes.) (Assist.)	nnell technique or	similar, for fixation of intraocula	r lens or repair of iris defect
42713	Fee: \$376.00 Bend	efit: 75% = \$282.00	85% = \$319.60	
	CATARACT, JUVENILE	e, removal of, incl	uding subsequent needlings (Ana	es.) (Assist.)
42716	<b>Fee:</b> \$1,195.70 <b>Bend</b>	efit: 75% = \$896.80	85% = \$1114.00	
			ULAR or LENS MATERIAL, vi which item 42698, 42702, 42716	
42719	Fee: \$519.00 Bend	efit: 75% = \$389.25	85% = \$441.15	
	Vitrectomy via pars plana	sclerotomy, inclu	ding one or more of the following	g:
	(a) removal of vitreous;			
	(b) division of vitreous bands;			
	(c) removal of epiretinal membranes;			
	(d) capsulotomy (Anaes.)	(Assist.)		
42725	Fee: \$1,338.45 Bend	e <b>fit:</b> 75% = \$1003.8	5	
	LIMBAL OR PARS PLA with items 42698, 42702,		AY combined with vitrectomy, no Anaes.) (Assist.)	ot being a service associated
42731	Fee: \$1,519.00 Bend	e <b>fit:</b> 75% = \$1139.2	5	
	Capsulotomy, other than b or 42731 applies (Anaes.)		than a service associated with a s	service to which item 42725
42734	Fee: \$300.75 Bend	efit: 75% = \$225.60	85% = \$255.65	
	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure.			
	(See para TN.8.121 of explanatory notes to this Category)         Fee: \$300.75       Benefit: 75% = \$225.60         85% = \$255.65			
42738	Extended Medicare Safe			and find the first of the
	therapeutic substances, or	the removal of aq	BER OR VITREOUS CAVITY, ueous or vitreous humours for dia rocedure, for a patient requiring a	agnostic or therapeutic
42739	(See para TN.8.121 of explan <b>Fee:</b> \$300.75 <b>Bend</b>	natory notes to this 0 efit: 75% = \$225.60		

T8. SUF	GICAL OPERATION	DNS	9. OPHTHALMOLOGY	
	Extended Medica	are Safety Net Cap: \$240.60		
			BSTANCES, or the removal of vitreous dure associated with other intraocular surgery.	
42740	Fee: \$300.75	of explanatory notes to this Category) Benefit: 75% = \$225.60 85% = \$255 are Safety Net Cap: \$240.60	5.65	
		eral depot injection of a therapeutic sub a due to age-related macular degeneration	stance, for the treatment of subfoveal choroidal on, 1 or more of (Anaes.)	
42741	(See para TN.8.81 o <b>Fee:</b> \$300.75	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$225.60 85% = \$255	5.65	
	ANTERIOR CHA (Assist.)	MBER, IRRIGATION OF BLOOD FI	ROM, as an independent procedure (Anaes.)	
42743	Fee: \$631.75	<b>Benefit:</b> 75% = \$473.85 85% = \$550	0.05	
	Needle revision of	glaucoma filtration bleb, following gla	aucoma filtering procedure (Anaes.)	
42744	Fee: \$300.55	<b>Benefit:</b> 75% = \$225.45 85% = \$255	5.50	
	GLAUCOMA, filtering operation for, where conservative therapies have failed, are likely to fail, or are contraindicated (Anaes.) (Assist.)			
42746	Fee: \$955.00	<b>Benefit:</b> 75% = \$716.25		
	GLAUCOMA, fil (Assist.)	tering operation for, where previous file	tering operation has been performed (Anaes.)	
42749	Fee: \$1,195.70	<b>Benefit:</b> 75% = \$896.80		
	GLAUCOMA, ins device (Anaes.) (A	• • •	g an extraocular reservoir for, such as a Molteno	
42752	(See para TN.8.83 o <b>Fee:</b> \$1,338.45	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$1003.85		
	GLAUCOMA, rea device (Anaes.)	noval of drainage device incorporating	an extraocular reservoir for, such as a Molteno	
42755	Fee: \$165.45	<b>Benefit:</b> 75% = \$124.10 85% = \$140	0.65	
		e treatment of primary congenital glauc aucoma drainage devices (Anaes.) (Ass	oma, excluding the minimally invasive sist.)	
42758	Fee: \$699.45	<b>Benefit:</b> 75% = \$524.60		
	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.)		IAE, as an independent procedure, other than	
42761	Fee: \$519.00	<b>Benefit:</b> 75% = \$389.25 85% = \$441	.15	
		ncluding excision of tumour of iris) OR · (Anaes.) (Assist.)	R IRIDOTOMY, as an independent procedure,	
42764	Fee: \$519.00	<b>Benefit:</b> 75% = \$389.25 85% = \$441	.15	
42767			RY BODY AND IRIS, excision of (Anaes.)	

T8. SUF	RGICAL OPERATIONS	9. OPHTHALMOLOGY
	(Assist.)	
	<b>Fee:</b> \$1,090.35 <b>Benefit:</b> 75% = \$817.80	
	CYCLODESTRUCTIVE procedures for the treatment of intract maximum of 2 treatments to that eye in a 2 year period (Anaes.)	
42770	(See para TN.8.82 of explanatory notes to this Category) <b>Fee:</b> \$294.80 <b>Benefit:</b> 75% = \$221.10 85% = \$250.60	
	DETACHED RETINA, pneumatic retinopexy for, not being a s item 42776 applies (Anaes.) (Assist.)	ervice associated with a service to which
42773	<b>Fee:</b> \$902.30 <b>Benefit:</b> 75% = \$676.75 85% = \$820.60	
	DETACHED RETINA, buckling or resection operation for (An	aes.) (Assist.)
42776	<b>Fee:</b> \$1,338.45 <b>Benefit:</b> 75% = \$1003.85	
	DETACHED RETINA, revision of scleral buckling operation for	or (Anaes.) (Assist.)
42779	<b>Fee:</b> \$1,669.45 <b>Benefit:</b> 75% = \$1252.10	
	LASER TRABECULOPLASTY, for the treatment of glaucoma of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.)	. Each treatment to 1 eye, to a maximum
42782	(See para TN.8.84 of explanatory notes to this Category) <b>Fee:</b> \$451.10 <b>Benefit:</b> 75% = \$338.35 85% = \$383.45	
	LASER TRABECULOPLASTY, for the treatment of glaucoma be demonstrated that a 5th or subsequent treatment to that eye ( 42782 applies) is indicated in a 2 year period (Anaes.) (Assist.)	
42783	(See para TN.8.84 of explanatory notes to this Category)           Fee: \$451.10         Benefit: 75% = \$338.35         85% = \$383.45	
	LASER IRIDOTOMY - each treatment episode to 1 eye, to a m year period (Anaes.) (Assist.)	aximum of 2 treatments to that eye in a 2
42785	(See para TN.8.85 of explanatory notes to this Category) <b>Fee:</b> \$353.35 <b>Benefit:</b> 75% = \$265.05 85% = \$300.35	
	LASER IRIDOTOMY - each treatment episode to 1 eye - where subsequent treatment to that eye (including any treatments to w 2 year period (Anaes.) (Assist.)	
42786	(See para TN.8.85 of explanatory notes to this Category) <b>Fee:</b> \$353.35 <b>Benefit:</b> 75% = \$265.05 85% = \$300.35	
	Laser capsulotomy—each treatment episode to one eye, to a may ear period—other than a service associated with a service to w (Assist.)	
42788	(See para TN.8.86 of explanatory notes to this Category) <b>Fee:</b> \$353.35 <b>Benefit:</b> 75% = \$265.05 85% = \$300.35	
	Laser capsulotomy—each treatment episode to one eye—if it ca subsequent treatment to that eye (including any treatments to wl 2 year period—other than a service associated with a service to (Assist.)	nich item 42788 applies) is indicated in a
42789	(See para TN.8.86 of explanatory notes to this Category)	

T8. SUF	GICAL OPERATIONS	5		9. OPHTHALMOLOGY
	<b>Fee:</b> \$353.35 <b>B</b>	<b>Benefit:</b> 75% = \$265.0	5 85% = \$300.35	
			rerial or fibrinolysis, excluding vi , to a maximum of 2 treatments to	
42791	(See para TN.8.87 of exp <b>Fee:</b> \$353.35 <b>B</b>	Clanatory notes to this Clanatory notes to this Clanatory and the second state of the		
	vitreous cavity -each	treatment to one eye ncluding any treatme	erial or fibrinolysis, excluding vi e—if it can be demonstrated that ents to which item 42791 applies	a third or subsequent
42792	(See para TN.8.87 of exp <b>Fee:</b> \$353.35 <b>B</b>	Clanatory notes to this C Senefit: 75% = \$265.0		
			wing glaucoma filtration surgery 2 year period (Anaes.)	<i>y</i> , each treatment to 1 eye, to
42794	(See para TN.8.88 of exp <b>Fee:</b> \$67.65 <b>B</b>	Planatory notes to this Cenefit: 75% = \$50.75		
	EPISCLERAL RADIO choroidal melanomas,	_	(Ruthenium 106 or Iodine 125), ) (Assist.)	for the treatment of
42801	Fee: \$1,049.70 B	<b>Benefit:</b> 75% = \$787.3	0	
	EPISCLERAL RADIO choroidal melanomas,		(Ruthenium 106 or Iodine 125), (Assist.)	for the treatment of
42802	Fee: \$524.70 B	<b>Senefit:</b> 75% = \$393.5	5	
			on to the sclera to localise the tun nomas, 1 or more (Anaes.) (Assi	
42805	Fee: \$586.50 B	<b>Benefit:</b> 75% = \$439.9	0 85% = \$504.80	
	IRIS TUMOUR, laser	photocoagulation of	(Anaes.) (Assist.)	
42806	Fee: \$353.35 B	<b>Benefit:</b> 75% = \$265.0	5 85% = \$300.35	
	PHOTOMYDRIASIS,		· · · · · · · · · · · · · · · · · · ·	
42807	Fee: \$355.80 B	<b>Benefit:</b> 75% = \$266.8	5 85% = \$302.45	
	Laser peripheral iridor			
42808		<b>Senefit:</b> 75% = \$266.8	5 85% - \$302.45	
42808		ation of, not being a	service associated with photody	namic therapy with
42809	<b>Fee:</b> \$451.10 <b>B</b>	<b>Benefit:</b> 75% = \$338.3	5 85% = \$383.45	
		TIC KERATECTOM	Y, by laser, for corneal scarring	or disease, excluding surgery
42810	<b>Fee:</b> \$567.70 <b>B</b>	<b>Benefit:</b> 75% = \$425.8	0 85% = \$486.00	
	TRANSPUPILLARY	THERMOTHERAP	Y, for treatment of choroidal and	l retinal tumours or vascular
	malformations (Anaes	.)		

T8. SUF	GICAL OPERAT	IONS		9. OPHTHALMOLOGY
	Fee: \$451.10	<b>Benefit:</b> 75% = \$338.35	85% = \$383.45	
	Removal of scle (Anaes.)	ral buckling material, from a	an eye having undergone previous	scleral buckling surgery
42812	Fee: \$165.45	<b>Benefit:</b> 75% = \$124.10	85% = \$140.65	
			oil or other liquid vitreous substitu us substitute is inserted (Anaes.) (	
42815	Fee: \$631.75	<b>Benefit:</b> 75% = \$473.85		
	RETINA, CRY0 item 42809 or 4		pendent procedure, or when perfor	rmed in conjunction with
42818	Fee: \$586.50	<b>Benefit:</b> 75% = \$439.90	85% = \$504.80	
	OCULAR TRA (Anaes.)	NSILLUMINATION, for the	e diagnosis and measurement of in	ntraocular tumours
42821	Fee: \$90.35	<b>Benefit:</b> 75% = \$67.80	85% = \$76.80	
	RETROBULBA	R INJECTION OF ALCOH	IOL OR OTHER DRUG, as an inc	dependent procedure
42824	Fee: \$69.90	<b>Benefit:</b> 75% = \$52.45	85% = \$59.45	
		RATION FOR, ON 1 OR BC patient aged 15 years or over	OTH EYES, the operation involvir er (Anaes.) (Assist.)	ng a total of 1 OR 2
42833	Fee: \$586.50	<b>Benefit:</b> 75% = \$439.90		
	MUSCLES, on	a patient aged 14 years or un	OTH EYES, the operation involvir ider, or where the patient has had r on a patient with concurrent thyr	previous squint, retinal or
42836	Fee: \$729.45	<b>Benefit:</b> 75% = \$547.10		
		RATION FOR, ON 1 OR BC patient aged 15 years or over	OTH EYES, the operation involvir er (Anaes.) (Assist.)	ng a total of 3 OR MORE
42839	Fee: \$699.45	<b>Benefit:</b> 75% = \$524.60		
	MUSCLES, on	a patient aged 14 years or un	OTH EYES, the operation involvir der, or where the patient has had r on a patient with concurrent thyr	previous squint, retinal or
42842	Fee: \$872.30	<b>Benefit:</b> 75% = \$654.25		
		NT OF ADJUSTABLE SUT eration for correction of squi	TURES, 1 or both eyes, as an inde nt (Anaes.)	pendent procedure
42845	(See para TN.8.89 <b>Fee:</b> \$189.40	of explanatory notes to this Ca Benefit: 75% = \$142.05		
	SQUINT, musch over (Anaes.) (A	÷ .	eim type, or similar operation) on	a patient aged 15 years or
42848	Fee: \$699.45	<b>Benefit:</b> 75% = \$524.60		
42851			eim type, or similar operation) on squint, retinal or extra ocular ope	

T8. SUF	RGICAL OPERATI	ONS 9. OPHTHALMOLOGY	
	or on a patient wi	th concurrent thyroid eye disease (Anaes.) (Assist.)	
	Fee: \$872.30	<b>Benefit:</b> 75% = \$654.25	
	RUPTURED ME (Anaes.) (Assist.)	DIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of	
42854	Fee: \$406.05	<b>Benefit:</b> 75% = \$304.55 85% = \$345.15	
		OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without used iris (Anaes.) (Assist.)	
42857	Fee: \$406.05	<b>Benefit:</b> 75% = \$304.55 85% = \$345.15	
	EYELID (upper or retractors (Anaes.	or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid ) (Assist.)	
42860	Fee: \$902.30	<b>Benefit:</b> 75% = \$676.75 85% = \$820.60	
	EYELID, recessio	on of (Anaes.) (Assist.)	
42863	Fee: \$774.55	<b>Benefit:</b> 75% = \$580.95 85% = \$692.85	
		TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior operation across the entire width of the eyelid (Anaes.) (Assist.)	
42866	Fee: \$751.85	<b>Benefit:</b> 75% = \$563.90 85% = \$670.15	
	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.)		
42869	Fee: \$549.00	<b>Benefit:</b> 75% = \$411.75 85% = \$467.30	
	EYEBROW, elevation of, for paretic states (Anaes.)		
42872	Fee: \$240.70	<b>Benefit:</b> 75% = \$180.55 85% = \$204.60	
		erapy, one eye, including the infusion of Verteporfin continuously through a peripheral thermal laser at a wavelength of 689nm, for the treatment of choroidal n.	
43021	Fee: \$455.05	<b>Benefit:</b> 75% = \$341.30 85% = \$386.80	
	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.		
43022	Fee: \$546.15	<b>Benefit:</b> 75% = \$409.65 85% = \$464.45	
	-	porfin for discontinued photodynamic therapy, where a session of therapy which would ad under item 43021 or 43022 has been discontinued on medical grounds.	
43023	Fee: \$88.50	<b>Benefit:</b> 75% = \$66.40 85% = \$75.25	
T8. SUF	GICAL OPERATI	ONS 10. OPERATIONS FOR OSTEOMYELITIS	
	Group T8. Surgio	al Operations	
		Subgroup 10. Operations For Osteomyelitis	

T8. SUF	GICAL OPERATIO	NS 10. OPERATIONS FOR OSTEOMYELITIS		
		ACUTE		
	OPERATION ON	PHALANX (Anaes.)		
43500	Fee: \$123.35	<b>Benefit:</b> 75% = \$92.55		
		STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.)		
43503	Fee: \$204.70	<b>Benefit:</b> 75% = \$153.55		
	OPERATION ON	HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)		
43506	Fee: \$356.35	<b>Benefit:</b> 75% = \$267.30		
	OPERATION ON	SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)		
43509	Fee: \$356.35	<b>Benefit:</b> 75% = \$267.30		
		CHRONIC		
	CARPUS, PHALA	SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, NX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.)		
43512	Fee: \$356.35	<b>Benefit:</b> 75% = \$267.30		
	OPERATION ON	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)		
43515	Fee: \$356.35	<b>Benefit:</b> 75% = \$267.30 85% = \$302.90		
	OPERATION ON	SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)		
43518	Fee: \$587.60	<b>Benefit:</b> 75% = \$440.70		
	OPERATION ON	SKULL (Anaes.) (Assist.)		
43521	Fee: \$464.50	<b>Benefit:</b> 75% = \$348.40		
		ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 5521 (Anaes.) (Assist.)		
43524	Fee: \$587.60	<b>Benefit:</b> 75% = \$440.70 85% = \$505.90		
T8. SUF	GICAL OPERATIO	NS 11. PAEDIATRIC		
	Group T8. Surgica	I Operations		
		Subgroup 11. Paediatric		
		SURGERY IN NEONATE OR YOUNG CHILD		
	INTESTINAL MA resection (Anaes.)	LROTATION with or without volvulus, laparotomy for, not involving bowel (Assist.)		
43801	Fee: \$957.30	<b>Benefit:</b> 75% = \$718.00		
		LROTATION with or without volvulus, laparotomy for, with bowel resection and or without formation of stoma (Anaes.) (Assist.)		
43804	Fee: \$1,019.25	<b>Benefit:</b> 75% = \$764.45		

T8. SUF	RGICAL OPERATI	ONS	11. PAEDIATRIC
	UMBILICAL, EF (Anaes.)	PIGASTRIC OR LINEA ALBA HERNIA, repair o	f, on a person under 10 years of age
43805	Fee: \$356.35	<b>Benefit:</b> 75% = \$267.30	
	DUODENAL AT (Assist.)	RESIA or STENOSIS, duodenoduodenostomy or o	duodenojejunostomy for (Anaes.)
43807	Fee: \$1,112.00	<b>Benefit:</b> 75% = \$834.00	
	JEJUNAL ATRE	SIA, bowel resection and anastomosis for, with or	without tapering (Anaes.) (Assist.)
43810	Fee: \$1,297.35	<b>Benefit:</b> 75% = \$973.05	
		EUS, laparotomy for, complicated by 1 or more of a or without meconium peritonitis (Anaes.) (Assist.)	associated volvulus, atresia, intesinal
43813	Fee: \$1,297.35	<b>Benefit:</b> 75% = \$973.05	
		A, COLONIC ATRESIA OR MECONIUM ILEUS i item 43813 applies, laparotomy for (Anaes.) (Ass	
43816	Fee: \$1,204.60	<b>Benefit:</b> 75% = \$903.45	
	Agangliosis Coli, (Anaes.) (Assist.)	laparotomy for, with or without frozen section bio	psies and formation of stoma
43819	Fee: \$972.95	<b>Benefit:</b> 75% = \$729.75	
	ANORECTAL M	ALFORMATION, laparotomy and colostomy for	(Anaes.) (Assist.)
43822	Fee: \$972.95	<b>Benefit:</b> 75% = \$729.75	
		IMENTARY OBSTRUCTION, laparotomy for, no oup applies (Anaes.) (Assist.)	t being a service to which any other
43825	Fee: \$1,112.00	<b>Benefit:</b> 75% = \$834.00	
		TAL NECROTISING ENTEROCOLITIS, laparote or stoma formation (Anaes.) (Assist.)	omy for, with resection, including
43828	Fee: \$1,228.55	<b>Benefit:</b> 75% = \$921.45	
	ACUTE NEONA laparotomy for (A	TAL NECROTISING ENTEROCOLITIS where n naes.) (Assist.)	o definitive procedure is possible,
43831	Fee: \$957.30	<b>Benefit:</b> 75% = \$718.00	
	BRANCHIAL FI	STULA, on a person under 10 years of age. Remo	val of, (Anaes.) (Assist.)
43832	Fee: \$652.95	<b>Benefit:</b> 75% = \$489.75	
	BOWEL RESEC stoma formation (	ΓΙΟΝ for necrotising enterocolitis stricture or strict Anaes.) (Assist.)	tures, including any anastomoses or
43834	Fee: \$1,112.00	<b>Benefit:</b> 75% = \$834.00	
		ED, INCARCERATED OR OBSTRUCTED HERN rson under 10 years of age (Anaes.) (Assist.)	IIA, repair of, without bowel
43835	Fee: \$677.65	<b>Benefit:</b> 75% = \$508.25	
43837	CONGENITAL I	DIAPHRAGMATIC HERNIA, repair by thoracic o	r abdominal approach, with

T8. SUF	RGICAL OPERATI	ONS 11. PAEDIATRIC
	diagnosis confirm	ned in the first 24 hours of life (Anaes.) (Assist.)
	Fee: \$1,389.90	<b>Benefit:</b> 75% = \$1042.45
		ernia, congential repair of, by thoracic or abdominal approach, not being a service to as 31569 to 31581 apply, on a person under 10 years of age (Anaes.) (Assist.)
43838	Fee: \$1,244.50	<b>Benefit:</b> 75% = \$933.40
		DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed of life and before 20 days of age (Anaes.) (Assist.)
43840	Fee: \$1,204.60	<b>Benefit:</b> 75% = \$903.45
		NGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to 3 or 43835 applies, on a person under 10 years of age (Anaes.) (Assist.)
43841	Fee: \$603.85	<b>Benefit:</b> 75% = \$452.90
		L ATRESIA (with or without repair of tracheo-oesophageal fistula), complete being a service to which item 43846 applies (Anaes.) (Assist.)
43843	Fee: \$1,853.35	<b>Benefit:</b> 75% = \$1390.05
		L ATRESIA (with or without repair of tracheo-oesophageal fistula), complete nfant of birth weight less than 1500 grams (Anaes.) (Assist.)
43846	Fee: \$1,992.30	<b>Benefit:</b> 75% = \$1494.25
	OESOPHAGEAI	L ATRESIA, gastrostomy for (Anaes.) (Assist.)
43849	Fee: \$509.65	<b>Benefit:</b> 75% = \$382.25
	OESOPHAGEAI anastomosis (Ana	L ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without aes.) (Assist.)
43852	Fee: \$1,621.55	<b>Benefit:</b> 75% = \$1216.20
	OESOPHAGEAI	L ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.)
43855	Fee: \$1,714.35	<b>Benefit:</b> 75% = \$1285.80
	OESOPHAGEAI	L ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.)
43858	Fee: \$602.25	<b>Benefit:</b> 75% = \$451.70
		CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR thoracotomy and lung resection for (Anaes.) (Assist.)
43861	Fee: \$1,668.05	<b>Benefit:</b> 75% = \$1251.05
		IS, operation for (Anaes.) (Assist.)
43864	Fee: \$1,251.05	<b>Benefit:</b> 75% = \$938.30
		IS or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.)
43867	Fee: \$695.00	<b>Benefit:</b> 75% = \$521.25
		containing small bowel only, operation for (Anaes.) (Assist.)
43870	Fee: \$972.95	<b>Benefit:</b> 75% = \$729.75
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T8. SUF	RGICAL OPERATI	ONS	11. PAEDIATRIC
	EXOMPHALOS	containing small bowel and other viscera, operation	for (Anaes.) (Assist.)
43873	Fee: \$1,297.35	<b>Benefit:</b> 75% = \$973.05	
	SACROCOCCY	GEAL TERATOMA, excision of, by posterior appro	oach (Anaes.) (Assist.)
43876	Fee: \$1,112.00	<b>Benefit:</b> 75% = \$834.00	
	SACROCOCCY (Anaes.) (Assist.)	GEAL TERATOMA, excision of, by combined post	terior and abdominal approach
43879	<b>Fee:</b> \$1,297.35	<b>Benefit:</b> 75% = \$973.05	
		TROPHY, operation for (Anaes.) (Assist.)	
43882	Fee: \$1,668.05	<b>Benefit:</b> 75% = \$1251.05 85% = \$1586.35	
		THORACIC SURGERY	
	TRACHEO-OES	OPHAGEAL FISTULA without atresia, division an	d repair of (Anaes.) (Assist.)
43900	Fee: \$1,112.00	<b>Benefit:</b> 75% = \$834.00	
	OESOPHAGEAI	L ATRESIA or CORROSIVE OESOPHAGEAL ST utilizing gastric tube, jejunum or colon (Anaes.) (As	
43903	Fee: \$1,853.35	<b>Benefit:</b> 75% = \$1390.05	
		resection of congenital, anastomic or corrosive stric item 43903 applies (Anaes.) (Assist.)	cture and anastomosis, not being a
43906	Fee: \$1,621.55	<b>Benefit:</b> 75% = \$1216.20	
	TRACHEOMAL	ACIA, aortopexy for (Anaes.) (Assist.)	
43909	Fee: \$1,621.55	<b>Benefit:</b> 75% = \$1216.20	
	THORACOTOM teratoma (Anaes.)	Y and excision of 1 or more of bronchogenic or ent ) (Assist.)	erogenous cyst or mediastinal
43912	Fee: \$1,532.00	<b>Benefit:</b> 75% = \$1149.00	
	EVENTRATION	I, plication of diaphragm for (Anaes.) (Assist.)	
43915	Fee: \$1,158.30	<b>Benefit:</b> 75% = \$868.75	
		ABDOMINAL SURGERY	
	HYPERTROPHI	C PYLORIC STENOSIS, pyloromyotomy for (Ana	es.) (Assist.)
43930	Fee: \$445.40	<b>Benefit:</b> 75% = \$334.05	
	IDIOPATHIC IN	TUSSUSCEPTION, laparotomy and manipulative r	reduction of (Anaes.) (Assist.)
43933	Fee: \$521.40	<b>Benefit:</b> 75% = \$391.05	
	INTUSSUSCEPT	FION, laparotomy and resection with anastomosis (A	Anaes.) (Assist.)
43936	Fee: \$972.95	<b>Benefit:</b> 75% = \$729.75	
	VENTRAL HER (Assist.)	NIA following neonatal closure of exomphalos or g	astroschisis, repair of (Anaes.)
	· /		

T8. SUF	RGICAL OPERATI	ONS 11. PAEDIATRIC
	ABDOMINAL W	VALL VITELLO INTESTINAL REMNANT, excision of (Anaes.)
43942	Fee: \$231.70	<b>Benefit:</b> 75% = \$173.80
	PATENT VITEL	LO INTESTINAL DUCT, excision of (Anaes.) (Assist.)
43945	Fee: \$972.95	<b>Benefit:</b> 75% = \$729.75
	UMBILICAL GR	RANULOMA, excision of, under general anaesthesia (Anaes.)
43948	Fee: \$139.10	<b>Benefit:</b> 75% = \$104.35
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, my (Anaes.) (Assist.)
43951	Fee: \$871.30	<b>Benefit:</b> 75% = \$653.50
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, (Anaes.) (Assist.)
43954	Fee: \$1,065.75	<b>Benefit:</b> 75% = \$799.35
		PHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or rnia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)
43957	Fee: \$1,158.30	<b>Benefit:</b> 75% = \$868.75
	ANORECTAL M	IALFORMATION, perineal anoplasty of (Anaes.) (Assist.)
43960	Fee: \$407.50	<b>Benefit:</b> 75% = \$305.65
	ANORECTAL M	IALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)
43963	Fee: \$1,621.55	<b>Benefit:</b> 75% = \$1216.20
	ANORECTAL M (Assist.)	IALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.)
43966	Fee: \$1,853.35	<b>Benefit:</b> 75% = \$1390.05
		LOACA, total correction of, with genital repair using posterior sagittal approach, with tomy (Anaes.) (Assist.)
43969	Fee: \$2,548.35	<b>Benefit:</b> 75% = \$1911.30
	CHOLEDOCHA	L CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)
43972	Fee: \$1,853.35	<b>Benefit:</b> 75% = \$1390.05
	CHOLEDOCHA	L CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)
43975	Fee: \$2,177.70	<b>Benefit:</b> 75% = \$1633.30
	BILIARY ATRE	SIA, portoenterostomy for (Anaes.) (Assist.)
43978	Fee: \$1,853.35	<b>Benefit:</b> 75% = \$1390.05
	NEPHROBLAST	TOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy luding associated biopsies, where no other intra-abdominal procedure is performed
43981	Fee: \$509.65	<b>Benefit:</b> 75% = \$382.25

T8. SUF	RGICAL OPERATIO	DNS 11. PAEDIATRIC			
	NEPHROBLAST	OMA, radical nephrectomy for (Anaes.) (Assist.)			
43984	Fee: \$1,297.35	<b>Benefit:</b> 75% = \$973.05			
	NEUROBLASTO	MA, radical excision of (Anaes.) (Assist.)			
43987	Fee: \$1,436.40	<b>Benefit:</b> 75% = \$1077.30			
		i, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends to sigmoid colon (Anaes.) (Assist.)			
43990	Fee: \$1,760.75	<b>Benefit:</b> 75% = \$1320.60			
		li, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends into descending or transverse colon with or without resiting (Assist.)			
43993	Fee: \$1,899.65	<b>Benefit:</b> 75% = \$1424.75			
		li, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or e ileocolic anastomosis (Anaes.) (Assist.)			
43996	Fee: \$2,131.35	<b>Benefit:</b> 75% = \$1598.55			
	Aganglionosis Col	li, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)			
43999	Fee: \$266.55	<b>Benefit:</b> 75% = \$199.95			
		RECTUM, examination of, on a person under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.)			
44101	Fee: \$334.05	<b>Benefit:</b> 75% = \$250.55			
		nation of, on a person 2 years of age or over, under general anaesthesia with full r removal of polyp or similar lesion (Anaes.) (Assist.)			
44102	Fee: \$256.95	<b>Benefit:</b> 75% = \$192.75			
	RECTAL PROLA under general anae	PSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, esthesia (Anaes.)			
44104	Fee: \$58.65	<b>Benefit:</b> 75% = \$44.00 85% = \$49.90			
	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person 2 years of age or over, under general anaesthesia (Anaes.)				
44105	Fee: \$45.10	<b>Benefit:</b> 75% = \$33.85 85% = \$38.35			
	INGUINAL HERN	NIA repair at age less than 12 months (Anaes.) (Assist.)			
44108	Fee: \$491.45	<b>Benefit:</b> 75% = \$368.60			
	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.)				
44111	Fee: \$575.65	<b>Benefit:</b> 75% = \$431.75 85% = \$493.95			
	INGUINAL HERI (Assist.)	NIA repair at age less than 12 months when orchidopexy also required (Anaes.)			
44114	Fee: \$575.65	<b>Benefit:</b> 75% = \$431.75			
		MISCELLANEOUS SURGERY			

T8. SUF		ONS	11. PAEDIATRIC
	LYMPHADENE (Assist.)	CTOMY, for atypical mycobacte	rial infection or other granulomatous disease (Anaes.)
44130	Fee: \$463.30	<b>Benefit:</b> 75% = \$347.50 85%	= \$393.85
	TORTICOLLIS,	open division of sternomastoid m	uscle for (Anaes.) (Assist.)
44133	Fee: \$367.75	<b>Benefit:</b> 75% = \$275.85	
	INGROWN TOP	NAIL, operation for, under gene	ral anaesthesia (Anaes.)
44136	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85%	= \$144.10
T8. SUF		ONS	12. AMPUTATIONS
	Group T8. Surgi	cal Operations	
		Subgroup	12. Amputations
	HAND, MIDCA	RPAL OR TRANSMETACARPA	AL, amputation of (Anaes.) (Assist.)
44325	Fee: \$295.70	<b>Benefit:</b> 75% = \$221.80 85%	= \$251.35
	HAND, FOREA	RM OR THROUGH ARM, ampu	tation of (Anaes.) (Assist.)
44328	Fee: \$356.35	<b>Benefit:</b> 75% = \$267.30	
	AMPUTATION	AT SHOULDER (Anaes.) (Assis	t.)
44331	Fee: \$587.60	<b>Benefit:</b> 75% = \$440.70	
	INTERSCAPUL	OTHORACIC AMPUTATION (A	Anaes.) (Assist.)
44334	Fee: \$1,194.25	<b>Benefit:</b> 75% = \$895.70 85%	= \$1112.55
	1 DIGIT of foot,	amputation of (Anaes.)	
44338	Fee: \$144.00	<b>Benefit:</b> 75% = \$108.00 85%	= \$122.40
	2 DIGITS of 1 fc	ot, amputation of (Anaes.)	
44342	Fee: \$219.95	<b>Benefit:</b> 75% = \$165.00	
	3 DIGITS of 1 fc	ot, amputation of (Anaes.) (Assis	t.)
44346	Fee: \$254.00	<b>Benefit:</b> 75% = \$190.50	
	4 DIGITS of 1 fo	ot, amputation of (Anaes.) (Assis	t.)
44350	Fee: \$288.20	<b>Benefit:</b> 75% = \$216.15 85%	= \$245.00
	5 DIGITS of 1 fc	ot, amputation of (Anaes.) (Assis	t.)
44354	Fee: \$329.80	<b>Benefit:</b> 75% = \$247.35	
	TOE, including r	netatarsal or part of metatarsal ea	ch toe, amputation of (Anaes.)
44358	Fee: \$183.90	<b>Benefit:</b> 75% = \$137.95	
		of the foot, performed for diabetic	on of, including if performed, excision of 1 or more c or other microvascular disease, excluding aftercare
44359	Fee: \$263.95	<b>Benefit:</b> 75% = \$198.00	

T8. SUF	GICAL OPERATIONS	12. AMPUTATIONS		
	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Ana	aes.) (Assist.)		
44361	<b>Fee:</b> \$356.35 <b>Benefit:</b> 75% = \$267.30			
	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputatio	n of (Anaes.) (Assist.)		
44364	<b>Fee:</b> \$295.70 <b>Benefit:</b> 75% = \$221.80			
	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW	KNEE (Anaes.) (Assist.)		
44367	<b>Fee:</b> \$521.95 <b>Benefit:</b> 75% = \$391.50			
	AMPUTATION AT HIP (Anaes.) (Assist.)			
44370	<b>Fee:</b> \$720.20 <b>Benefit:</b> 75% = \$540.15			
	HINDQUARTER, amputation of (Anaes.) (Assist.)			
44373	<b>Fee:</b> \$1,478.40 <b>Benefit:</b> 75% = \$1108.80 85% = \$1396.70			
	AMPUTATION STUMP, reamputation of, to provide adequate	e skin and muscle cover (Assist.)		
44376	Derived Fee: 75% of the original amputation fee			
T8. SUF	RGICAL OPERATIONS 13. PLASTIC	AND RECONSTRUCTIVE SURGERY		
	Group T8. Surgical Operations			
	Subgroup 13. Plastic And Reconstructive Surgery			
	GENERAL			
	Single stage local muscle flap repair, on eyelid, nose, lip, neck, association with any of items 31356 to 31376 (Anaes.)	hand, thumb, finger or genitals not in		
45000	<b>Fee:</b> \$541.35 <b>Benefit:</b> 75% = \$406.05 85% = \$460.15			
	Single stage local myocutaneous flap repair to one defect, simple and small not in association with any of items 31356 to 31376 (Anaes.)			
15002	<b>Fee:</b> \$601.65 <b>Benefit:</b> 75% = \$451.25 85% = \$519.95			
45003	Extended Medicare Safety Net Cap: \$481.35           SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIL	R to 1 defect (nectoralis major latissimus		
	dorsi, or similar large muscle) (Anaes.) (Assist.)	it to T derect, (pectoralis major, latissimus		
45006	<b>Fee:</b> \$1,037.65 <b>Benefit:</b> 75% = \$778.25			
	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simpl	e and small (Anaes.) (Assist.)		
45009	<b>Fee:</b> \$379.05 <b>Benefit:</b> 75% = \$284.30			
	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defer gracilis or similar large muscle) (Anaes.) (Assist.)	ct, (pectoralis major, gastrocnemius,		
45012	<b>Fee:</b> \$635.00 <b>Benefit:</b> 75% = \$476.25			
	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.)			
45015	<b>Fee:</b> \$300.75 <b>Benefit:</b> 75% = \$225.60			
45018	Dermis, dermofat or fascia graft (excluding transfer of fat by in with neurosurgical services for spinal disorders mentioned in an			

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(Assist.)
	<b>Fee:</b> \$473.65 <b>Benefit:</b> 75% = \$355.25 85% = \$402.65
	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.)
45019	(See para TN.8.90 of explanatory notes to this Category) <b>Fee:</b> \$396.70 <b>Benefit:</b> 75% = \$297.55
	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 speciality - 1 session only in a 12 month period (Anaes.)
45020	(See para TN.8.90 of explanatory notes to this Category) <b>Fee:</b> \$396.70 <b>Benefit:</b> 75% = \$297.55
	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)
45021	(See para TN.8.91 of explanatory notes to this Category)           Fee: \$177.35         Benefit: 75% = \$133.05         85% = \$150.75
	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)
45024	(See para TN.8.91 of explanatory notes to this Category)           Fee: \$398.55         Benefit: 75% = \$298.95         85% = \$338.80
	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.)
45025	(See para TN.8.91 of explanatory notes to this Category)         Fee: \$177.35       Benefit: 75% = \$133.05       85% = \$150.75         Extended Medicare Safety Net Cap: \$141.90
	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.)
45026	(See para TN.8.91 of explanatory notes to this Category)         Fee: \$398.55       Benefit: 75% = \$298.95       85% = \$338.80         Extended Medicare Safety Net Cap: \$318.85
	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.)
45027	<b>Fee:</b> \$120.35 <b>Benefit:</b> 75% = \$90.30 85% = \$102.30
	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.)
45030	<b>Fee:</b> \$129.25 <b>Benefit:</b> 75% = \$96.95 85% = \$109.90
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial

	\$180.55 85% = \$204.60	
ANGIOMA (haemangioma or lymph excision of (Anaes.) (Assist.)		
excision of (Anaes.) (Assist.)		
<b>Fee:</b> \$702.05 <b>Benefit:</b> 75% = 3	angioma or both), large and deep, involving muscles or nerves,	
	\$526.55	
ANGIOMA (haemangioma or lymph	angioma or both) of neck, deep, excision of (Anaes.) (Assist.)	
<b>Fee:</b> \$1,128.05 <b>Benefit:</b> 75% = 5	\$846.05	
ARTERIOVENOUS MALFORMAT (Anaes.)	TON (3 centimetres or less) of superficial tissue, excision of	
<b>Fee:</b> \$240.70 <b>Benefit:</b> 75% = 5	8180.55  85% = 204.60	
ARTERIOVENOUS MALFORMAT	TON, (greater than 3 centimetres), excision of (Anaes.) (Assist.)	
<b>Fee:</b> \$308.40 <b>Benefit:</b> 75% = 5	\$231.30 85% = \$262.15	
ARTERIOVENOUS MALFORMAT excision of (Anaes.)	TON on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals,	
<b>Fee:</b> \$308.40 <b>Benefit:</b> 75% = 5	\$231.30 85% = \$262.15	
	(Anaes.) (Assist.)	
<b>Fee:</b> \$774.55 <b>Benefit:</b> 75% = 3	\$580.95	
Contour reconstruction for open repair of contour defects, due to deformity, requiring insertion of a non- biological implant, if it can be demonstrated that contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery), excluding the following:		
(a) insertion of a non-biological implant that is a component of another service listed in Group T8;		
(b) injection of liquid or semisolid material;		
(c) oral and maxillofacial implant ser	vices provided under item 52321;	
(d) services to insert mesh (Anaes.) (	Assist.)	
<b>Fee:</b> \$473.75 <b>Benefit:</b> 75% = 3	\$355.35	
· 1	scharotomy of (including all incisions), for acute compartment (Assist.)	
SKIN FLAP SURGERY		
Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.)		
<b>Fee:</b> \$284.35 <b>Benefit:</b> 75% = 3	\$213.30 85% = \$241.70	
	Fee: \$1,128.05Benefit: 75% = :ARTERIOVENOUS MALFORMAT (Anaes.)Fee: \$240.70Benefit: 75% = :ARTERIOVENOUS MALFORMATFee: \$308.40Benefit: 75% = :ARTERIOVENOUS MALFORMAT excision of (Anaes.)Fee: \$308.40Benefit: 75% = :Contour reconstruction for open repa biological implant, if it can be demor deformity is secondary to congenital previous cosmetic surgery), excluding(a) insertion of a non-biological impl(b) injection of liquid or semisolid mail (c) oral and maxillofacial implant ser (d) services to insert mesh (Anaes.) (Fee: \$473.75Benefit: 75% = :LIMB OR CHEST, decompression existing syndrome secondary to burn (Anaes.) (See para TN.8.92 of explanatory notes to baldness and excluding H-flap or dou 31376 (Anaes.)Single stage local flap, if indicated to baldness.Single stage local flap, if indicated to 	

T8. SUF	<b>RGICAL OPERATIONS</b>	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	removal of a malignant or non-malignant sk	clinically indicated to repair one surgical excision made in the in lesion (only in association with items 31000, 31001, , 31369, 31370, 31371, 31373 or 31376)-may be claimed	
45201	(See para TN.8.93 of explanatory notes to this C Fee: \$413.95 Benefit: 75% = \$310.50		
	•	clinically indicated to repair one surgical excision made in the in lesion in a patient, if the clinical relevance of the 's record and either:	
	(a) item 45201 applies and additional flap	o repair is required for the same defect; or	
	(b) item 45201 does not apply and either:		
	(i) the patient has severe pre-existing s	carring, severe skin atrophy or sclerodermoid changes; or	
	(ii) the repair is contiguous with a free	margin (Anaes.)	
45202	(See para TN.8.93, TN.8.126 of explanatory note Fee: \$413.95 Benefit: 75% = \$310.50		
		one defect, complicated or large, excluding flap for male uble advancement flap not in association with any of items	
45203	(See para TN.8.93 of explanatory notes to this Category) <b>Fee:</b> \$406.05 <b>Benefit:</b> 75% = \$304.55 85% = \$345.15 <b>Extended Medicare Safety Net Cap:</b> \$324.85		
		one defect, on eyelid, nose, lip, ear, neck, hand, thumb, ouble advancement flap not in association with any of items	
45206	(See para TN.8.93 of explanatory notes to this C           Fee: \$383.55         Benefit: 75% = \$287.70           Extended Medicare Safety Net Cap: \$306	85% = \$326.05	
	H-flap or double advancement flap if indica in association with any of items 31356 to 31	ted to repair one defect, on eyelid, eyebrow or forehead not 376 (Anaes.)	
45207	<b>Fee:</b> \$383.55 <b>Benefit:</b> 75% = \$287.70	85% = \$326.05	
	DIRECT FLAP REPAIR (cross arm, abdon	ninal or similar), first stage (Anaes.) (Assist.)	
45209	<b>Fee:</b> \$473.75 <b>Benefit:</b> 75% = \$355.35	5 85% = \$402.70	
	DIRECT FLAP REPAIR (cross arm, abdon	ninal or similar), second stage (Anaes.)	
45212	<b>Fee:</b> \$235.05 <b>Benefit:</b> 75% = \$176.30	) 85% = \$199.80	
	DIRECT FLAP REPAIR, cross leg, first sta	ge (Anaes.) (Assist.)	
45215	<b>Fee:</b> \$1,014.05 <b>Benefit:</b> 75% = \$760.55	5	
	DIRECT FLAP REPAIR, cross leg, second	stage (Anaes.) (Assist.)	
45218	<b>Fee:</b> \$454.85 <b>Benefit:</b> 75% = \$341.15	5	
45221	DIRECT FLAP REPAIR, small (cross finge	er or similar), first stage (Anaes.)	

T8. SUF	GICAL OPERATIO	NS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$261.55	<b>Benefit:</b> 75% = \$196.20	85% = \$222.35	
	DIRECT FLAP RE	EPAIR, small (cross finge	er or similar), second stage (Anaes.)	
45224	Fee: \$117.55	<b>Benefit:</b> 75% = \$88.20	85% = \$99.95	
	INDIRECT FLAP	OR TUBED PEDICLE,	formation of (Anaes.) (Assist.)	
45227	<b>Fee:</b> \$445.40	<b>Benefit:</b> 75% = \$334.05	5 85% = \$378.60	
	DIRECT OR INDI	RECT FLAP OR TUBE	D PEDICLE, delay of (Anaes.)	
45230	Fee: \$222.75	<b>Benefit:</b> 75% = \$167.10	) 85% = \$189.35	
	INDIRECT FLAP site (Anaes.) (Assis		preparation of intermediate or final site and attachment to the	
45233	Fee: \$473.75	<b>Benefit:</b> 75% = \$355.35	5 85% = \$402.70	
	INDIRECT FLAP	OR TUBED PEDICLE,	spreading of pedicle, as a separate procedure (Anaes.)	
45236	Fee: \$371.50	<b>Benefit:</b> 75% = \$278.65	5	
	DIRECT, INDIRE which item 45240		evision of, by incision and suture, not being a service to	
45239	Fee: \$261.55	<b>Benefit:</b> 75% = \$196.20	85% = \$222.35	
		CT OR LOCAL FLAP, r 98 or 45499 applies (Ana	evision of, by liposuction, not being a service to which item nes.)	
45240	Fee: \$261.55	<b>Benefit:</b> 75% = \$196.20	85% = \$222.35	
	FREE GRAFTS			
	FREE GRAFTING	6 (split skin) of a granulat	ing area, small (Anaes.)	
45400	Fee: \$204.70	<b>Benefit:</b> 75% = \$153.55	5 85% = \$174.00	
	FREE GRAFTING	6 (split skin) of a granulat	ing area, extensive (Anaes.) (Assist.)	
45403	Fee: \$407.50	<b>Benefit:</b> 75% = \$305.65	5 85% = \$346.40	
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.)			
45406	(See para TN.8.94 of <b>Fee:</b> \$451.10	explanatory notes to this Carrier Benefit: 75% = \$338.35		
		G (split skin) to burns, inc cent of total body surface	luding excision of burnt tissue - involving 3 per cent or more e (Anaes.) (Assist.)	
45409	(See para TN.8.94 of <b>Fee:</b> \$601.65	explanatory notes to this C Benefit: 75% = \$451.25		
		G (split skin) to burns, inc cent of total body surface	luding excision of burnt tissue - involving 6 per cent or more e (Anaes.) (Assist.)	
45412	(See para TN.8.94 of <b>Fee:</b> \$827.30	explanatory notes to this Carrier Benefit: 75% = \$620.50		
		6 (split skin) to burns, inc r cent of total body surfac	luding excision of burnt tissue - involving 9 per cent or more ce (Anaes.) (Assist.)	
45415	(See para TN.8.94 of	explanatory notes to this C	ategory)	

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	<b>Fee:</b> \$902.30 <b>Benefit:</b> 75%	b = \$676.75
		burns, including excision of burnt tissue - involving 12 per cent or total body surface (Anaes.) (Assist.)
45418	(See para TN.8.94 of explanatory not <b>Fee:</b> \$977.55 <b>Benefit:</b> 75%	
	FREE GRAFTING (split skin) to	1 defect, including elective dissection, small (Anaes.)
45439	<b>Fee:</b> \$284.35 <b>Benefit:</b> 75%	b = \$213.30 $85% = $241.70$
	FREE GRAFTING (split skin) to	1 defect, including elective dissection, extensive (Anaes.) (Assist.)
45442	<b>Fee:</b> \$586.50 <b>Benefit:</b> 75%	b = \$439.90  85% = \$504.80
	FREE GRAFTING (split skin) as (including insertion of, and remov	inlay graft to 1 defect including elective dissection using a mould val of mould) (Anaes.) (Assist.)
45445	<b>Fee:</b> \$556.60 <b>Benefit:</b> 75%	b = \$417.45  85% = \$474.90
		1 defect, including elective dissection on eyelid, nose, lip, ear, neck, ot being a service to which item 45442 or 45445 applies (Anaes.)
45448	<b>Fee:</b> \$376.00 <b>Benefit:</b> 75%	5 = \$282.00  85% = \$319.60
	FREE GRAFTING (full thickness (Assist.)	s), to 1 defect, excluding grafts for male pattern baldness (Anaes.)
45451	<b>Fee:</b> \$473.75 <b>Benefit:</b> 75%	b = \$355.35  85% = \$402.70
		burns, including excision of burnt tissue - involving 15 percent or otal body surface - one surgeon (Anaes.) (Assist.)
45460	<b>Fee:</b> \$1,253.30 <b>Benefit:</b> 75%	5 = \$940.00
		burns, including excision of burnt tissue - involving 15 percent or otal body surface - conjoint surgery, principal surgeon (Anaes.)
45461	<b>Fee:</b> \$893.25 <b>Benefit:</b> 75%	6 = \$669.95
		burns, including excision of burnt tissue - involving 15 percent or otal body surface - conjoint surgery, co- surgeon (Assist.)
45462	<b>Fee:</b> \$674.05 <b>Benefit:</b> 75%	6 = \$505.55
		burns, including excision of burnt tissue - involving 20 percent or otal body surface - one surgeon (Anaes.) (Assist.)
45464	<b>Fee:</b> \$1,913.10 <b>Benefit:</b> 75%	6 = \$1434.85
		burns, including excision of burnt tissue - involving 20 percent or otal body surface - conjoint surgery, principal surgeon (Anaes.)
45465	<b>Fee:</b> \$1,363.00 <b>Benefit:</b> 75%	b = \$1022.25 $85% = $1281.30$
		burns, including excision of burnt tissue - involving 20 percent or otal body surface - conjoint surgery, co-surgeon (Assist.)
45466	<b>Fee:</b> \$1,027.95 <b>Benefit:</b> 75%	b = \$771.00 $85% = $946.25$

T8. SUF	<b>RGICAL OPERATIONS</b>	13. PLASTIC AND RECONSTRUCTIVE SURGERY
		rns, including excision of burnt tissue - involving 30 percent or l body surface - conjoint surgery, principal surgeon (Anaes.)
45468	<b>Fee:</b> \$1,832.65 <b>Benefit:</b> 75% =	\$1374.50
		rns, including excision of burnt tissue - involving 30 percent or l body surface - conjoint surgery, co-surgeon (Assist.)
45469	<b>Fee:</b> \$1,382.70 <b>Benefit:</b> 75% =	\$1037.05 85% = \$1301.00
		rns, including excision of burnt tissue - involving 40 percent or l body surface - conjoint surgery, principal surgeon (Anaes.)
45471	<b>Fee:</b> \$2,303.65 <b>Benefit:</b> 75% =	\$1727.75 85% = \$2221.95
		rns, including excision of burnt tissue - involving 40 percent or l body surface - conjoint surgery, co-surgeon (Assist.)
45472	<b>Fee:</b> \$1,737.60 <b>Benefit:</b> 75% =	\$1303.20 85% = \$1655.90
		rns, including excision of burnt tissue - involving 50 percent or l body surface - conjoint surgery, principal surgeon (Anaes.)
45474	<b>Fee:</b> \$2,773.30 <b>Benefit:</b> 75% =	2080.00  85% = 2691.60
		rns, including excision of burnt tissue - involving 50 percent or l body surface - conjoint surgery, co-surgeon (Assist.)
45475	Fee: \$2,092.45 Benefit: 75% =	\$1569.35 85% = \$2010.75
		rns, including excision of burnt tissue - involving 60 percent or l body surface - conjoint surgery, principal surgeon (Anaes.)
45477	<b>Fee:</b> \$3,243.00 <b>Benefit:</b> 75% =	\$2432.25 85% = \$3161.30
		rns, including excision of burnt tissue - involving 60 percent or l body surface - conjoint surgery, co-surgeon (Assist.)
45478	<b>Fee:</b> \$2,446.05 <b>Benefit:</b> 75% =	\$1834.55 85% = \$2364.35
		rns, including excision of burnt tissue - involving 70 percent or l body surface - conjoint surgery, principal surgeon (Anaes.)
45480	<b>Fee:</b> \$3,712.60 <b>Benefit:</b> 75% =	\$2784.45 85% = \$3630.90
		rns, including excision of burnt tissue - involving 70 percent or l body surface - conjoint surgery, co-surgeon (Assist.)
45481	<b>Fee:</b> \$2,801.10 <b>Benefit:</b> 75% =	\$2100.85 85% = \$2719.40
		rns, including excision of burnt tissue - involving 80 percent or surgery, principal surgeon (Anaes.) (Assist.)
45483	<b>Fee:</b> \$4,229.95 <b>Benefit:</b> 75% =	\$3172.50 85% = \$4148.25
45484	FREE GRAFTING (split skin) to bu	rns, including excision of burnt tissue - involving 80 percent or

T8. SUF	GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	more of total body	y surface - conjoint surgery, co-surgeon (Assist.)
	Fee: \$3,191.50	<b>Benefit:</b> 75% = \$2393.65 85% = \$3109.80
		G (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear ad (Anaes.) (Assist.)
45485	Fee: \$527.70	<b>Benefit:</b> 75% = \$395.80
		G (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior , chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.)
45486	Fee: \$451.10	<b>Benefit:</b> 75% = \$338.35
	FREE GRAFTIN (Assist.)	G (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.)
45487	Fee: \$406.05	<b>Benefit:</b> 75% = \$304.55 85% = \$345.15
	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the ssist.)
45488	Fee: \$451.10	<b>Benefit:</b> 75% = \$338.35
	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the ssist.)
45489	Fee: \$676.80	<b>Benefit:</b> 75% = \$507.60 85% = \$595.10
	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the ssist.)
45490	Fee: \$902.50	<b>Benefit:</b> 75% = \$676.90
	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the ssist.)
45491	Fee: \$1,128.05	<b>Benefit:</b> 75% = \$846.05
	FREE GRAFTIN hand (Anaes.) (As	G (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the ssist.)
45492	Fee: \$1,353.60	<b>Benefit:</b> 75% = \$1015.20
	FREE GRAFTIN (Anaes.) (Assist.)	G (split skin) to burns, including excision of burnt tissue - portion of digit of hand
45493	Fee: \$406.05	<b>Benefit:</b> 75% = \$304.55
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.)	
45494	Fee: \$1,638.70	<b>Benefit:</b> 75% = \$1229.05 85% = \$1557.00
		OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
	FLAP, free tissue	transfer using microvascular techniques - revision of, by open operation (Anaes.)
45496	Fee: \$416.05	<b>Benefit:</b> 75% = \$312.05
		transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>of</i> , by liposuction (Anaes.)
	*	

GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>f</i> , by liposuction - first stage (Anaes.)
Fee: \$261.55	<b>Benefit:</b> 75% = \$196.20
	transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>f</i> , by liposuction - second stage (Anaes.)
Fee: \$195.00	<b>Benefit:</b> 75% = \$146.25
	LAR REPAIR using microsurgical techniques, with restoration of continuity of artery xtremity or digit (Anaes.) (Assist.)
Fee: \$1,090.35	<b>Benefit:</b> 75% = \$817.80
MICROVASCUL limb or digit (Ana	AR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of aes.) (Assist.)
Fee: \$1,774.70	<b>Benefit:</b> 75% = \$1331.05
MICROVASCUL limb or digit (Ana	LAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of aes.) (Assist.)
Fee: \$1,774.70	<b>Benefit:</b> 75% = \$1331.05
MICRO-ARTERI	IAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.)
Fee: \$2,030.35	<b>Benefit:</b> 75% = \$1522.80
	LAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of etting in of free flap (Anaes.) (Assist.)
Fee: \$1,774.70	<b>Benefit:</b> 75% = \$1331.05
	AR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of etting in of free flap (Anaes.) (Assist.)
Fee: \$1,774.70	<b>Benefit:</b> 75% = \$1331.05
	neck, not more than 3 cm in length, revision of, where undertaken in the operating tal, or where performed by a specialist in the practice of his or her specialty (Anaes.)
(See para TN.8.95 o <b>Fee:</b> \$219.95	of explanatory notes to this Category) <b>Benefit:</b> $75\% = $165.00$ $85\% = $187.00$
	neck, more than 3 cm in length, revision of, where undertaken in the operating theatre where performed by a specialist in the practice of his or her specialty (Anaes.)
(See para TN.8.95 o <b>Fee:</b> \$295.70	of explanatory notes to this Category) <b>Benefit:</b> $75\% = $221.80$ $85\% = $251.35$
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 is the practice of his or her specialty (Anaes.)	
(See para TN.8.95 o <b>Fee:</b> \$186.50	of explanatory notes to this Category) Benefit: $75\% = $139.90$ $85\% = $158.55$
where undertaken	on face or neck, more than 7 cms in length, revision of, as an independent procedure, in the operating theatre of a hospital, or where performed by a specialist in the her speciality (Anaes.)
F	
	FLAP, free tissue staged revision ofFee: \$261.55FLAP, free tissue staged revision ofFee: \$195.00MICROVASCUI or vein of distal e.Fee: \$1,090.35MICROVASCUI limb or digit (AnaFee: \$1,774.70MICROVASCUI limb or digit (AnaFee: \$1,774.70MICROVASCUI limb or digit (AnaFee: \$1,774.70MICROVASCUI limb or digit (AnaFee: \$1,774.70MICROVASCUI tissue including seFee: \$1,774.70MICROVASCUI tissue including seFee: \$1,774.70SCAR, of face or theatre of a hospital (See para TN.8.95 or Fee: \$219.95SCAR, of face or of a hospital, or we (See para TN.8.95 or Fee: \$295.70SCAR, other than procedure, where the practice of his (See para TN.8.95 or Fee: \$186.50SCAR, other than procedure, where the practice of his SCAR, other than procedure, where the practice of his SCAR, other than procedure, where the practice of his

T8. SUF	3. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	<b>Fee:</b> \$225.70 <b>Bene</b>	<b>fit:</b> 75% = \$169.30	85% = \$191.85	
	EXTENSIVE BURN SCA correction of scar contract		re than 1 percent of body surface area), excision of, for t.)	
45519	<b>Fee:</b> \$429.05 <b>Bene</b>	<b>fit:</b> 75% = \$321.80		
	REDUCTION MAMMAP	LASTY (unilatera	l) with surgical repositioning of nipple (Anaes.) (Assist.)	
45520	<b>Fee:</b> \$900.45 <b>Bene</b>	<b>fit:</b> 75% = \$675.35		
	REDUCTION MAMMAP treatment of gynaecomasti		l) without surgical repositioning of nipple, excluding the sist.)	
45522	<b>Fee:</b> \$631.75 <b>Bene</b>	<b>fit:</b> 75% = \$473.85		
	MAMMAPLASTY, AUG limited to 1 breast (Anaes.		significant breast asymmetry where the augmentation is	
45524	(See para TN.8.96 of explana Fee: \$741.65 Bene	tory notes to this Cat <b>fit:</b> 75% = \$556.25	egory)	
	MAMMAPLASTY, AUG	MENTATION, (ur	nilateral), following mastectomy (Anaes.) (Assist.)	
45527	(See para TN.8.96 of explana <b>Fee:</b> \$741.65 <b>Bene</b>	tory notes to this Cat <b>fit:</b> 75% = \$556.25	egory)	
	MAMMAPLASTY, AUGMENTATION, bilateral, <u>not being a service to which Item 45527 applies</u> , <i>where it can be demonstrated</i> 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.)			
45528	(See para TN.8.96 of explana <b>Fee:</b> \$1,112.35 <b>Bene</b>	tory notes to this Cat <b>fit:</b> 75% = \$834.30	egory)	
	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, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177 or 30179 applies			
	(H) (Anaes.) (Assist.)			
45530	(See para TN.8.97 of explana <b>Fee:</b> \$1,099.40 <b>Bene</b>	tory notes to this Cat fit: 75% = \$824.55	egory)	
		nd breast tissue flag	sharing technique (first stage) including breast reduction, p, split skin graft to pedicle of flap or other similar	
45533	(See para TN.8.8 of explanato Fee: \$1,245.10 Bene	ory notes to this Cate <b>fit:</b> 75% = \$933.85	gory)	
			sharing technique (second stage) including division of of donor site or other similar procedure (Anaes.) (Assist.)	
45536	<b>Fee:</b> \$457.85 <b>Bene</b>	<b>fit:</b> 75% = \$343.40		
	BREAST RECONSTRUC	TION (unilateral),	following mastectomy, using tissue expansion - insertion or subsequent expansion injections (Anaes.) (Assist.)	
45539	Fee: \$1,071.20 Bene	<b>fit:</b> 75% = \$803.40		
45542			following mastectomy, using tissue expansion - removal of	

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	tissue expansion unit and insertion of perm	anent prosthesis (Anaes.) (Assist.)
	<b>Fee:</b> \$613.40 <b>Benefit:</b> 75% = \$460.0	5
	NIPPLE OR AREOLA or both, reconstruc	tion of, by any surgical technique (Anaes.) (Assist.)
45545	(See para TN.8.100 of explanatory notes to this <b>Fee:</b> \$622.55 <b>Benefit:</b> 75% = \$466.9 <b>Extended Medicare Safety Net Cap:</b> \$498	5 85% = \$540.85
	NIPPLE OR AREOLA or both, intraderma mastectomy or for congenital absence of ni	l colouration of, following breast reconstruction after pple
45546	(See para TN.8.100 of explanatory notes to this <b>Fee:</b> \$197.85 <b>Benefit:</b> 75% = \$148.4	
	BREAST PROSTHESIS, removal of, as ar	n independent procedure (Anaes.)
45548	<b>Fee:</b> \$276.80 <b>Benefit:</b> 75% = \$207.6	0 85% = \$235.30
	BREAST PROSTHESIS, removal of, with	excision of fibrous capsule (Anaes.) (Assist.)
45551	<b>Fee:</b> \$443.70 <b>Benefit:</b> 75% = \$332.8	0
	BREAST PROSTHESIS, removal of, with (Anaes.) (Assist.)	excision of fibrous capsule and replacement of prosthesis
45552	(See para TN.8.98 of explanatory notes to this C Fee: \$638.65 Benefit: 75% = \$479.0	
		acement with another prosthesis, following medical f prosthetic material, or capsule formation). (Anaes.) (Assist.)
45553	(See para TN.8.98 of explanatory notes to this <b>C</b> <b>Fee:</b> \$638.65 <b>Benefit:</b> 75% = \$479.0	
		acement with another prosthesis, following medical of prosthetic material, or capsule formation), where new rous capsule (Anaes.) (Assist.)
45554	(See para TN.8.98 of explanatory notes to this C <b>Fee:</b> \$699.45 <b>Benefit:</b> 75% = \$524.6	
	SILICONE BREAST PROSTHESIS, remo prosthesis (Anaes.) (Assist.)	oval of and replacement with prosthesis other than silicone gel
45555	(See para TN.8.98 of explanatory notes to this C Fee: \$638.65 <b>Benefit:</b> 75% = \$479.0	
	BREAST PTOSIS, correction of (unilatera (Anaes.) (Assist.)	l), to match the position of the contralateral breast (H)
45556	(See para TN.8.99 of explanatory notes to this C <b>Fee:</b> \$766.05 <b>Benefit:</b> 75% = \$574.5	
	lactation, when performed not less than 1 y pregnancy, and <i>where it can be demonstrate</i>	bexy by any means (unilateral), following pregnancy and rear, and not more than 7 years after the end of the most recent <i>ted</i> that the nipple is inferior to the infra-mammary groove, the to which item 45522 applies (Anaes.) (Assist.)
45557	(See para TN.8.99 of explanatory notes to this C <b>Fee:</b> \$766.05 <b>Benefit:</b> 75% = \$574.5	

T8. SUR	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	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 <i>where it can be demonstrated</i> 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.)
45558	(See para TN.8.99 of explanatory notes to this Category) <b>Fee:</b> \$1,148.95 <b>Benefit:</b> 75% = \$861.75
	TUBEROUS, TUBULAR OR CONSTRICTED BREAST, where it can be demonstrated, correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.)
45559	(See para TN.8.99 of explanatory notes to this Category) <b>Fee:</b> \$1,136.80 <b>Benefit:</b> 75% = \$852.60 85% = \$1055.10
	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.)
45560	Fee:         \$473.65         Benefit:         75% = \$355.25         85% = \$402.65           Extended Medicare Safety Net Cap:         \$165.80
	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.)
45561	<b>Fee:</b> \$1,774.70 <b>Benefit:</b> 75% = \$1331.05
	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.)
45562	<b>Fee:</b> \$1,099.40 <b>Benefit:</b> 75% = \$824.55 85% = \$1017.70
	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.)
45563	<b>Fee:</b> \$1,099.40 <b>Benefit:</b> 75% = \$824.55 85% = \$1017.70
	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 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, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, principal specialist surgeon (H) (Anaes.) (Assist.)
45564	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$2,546.30 <b>Benefit:</b> 75% = \$1909.75
	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 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, other than a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 30179, 45501, 45502, 45504, 45505 or 45562 applies-conjoint surgery, conjoint specialist surgeon (H) (Assist.)
45565	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$1,909.80 <b>Benefit:</b> 75% = \$1432.35

T8. SUF	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)
	<b>Fee:</b> \$1,071.20 <b>Benefit:</b> 75% = \$803.40
	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)
45568	<b>Fee:</b> \$443.70 <b>Benefit:</b> 75% = \$332.80
	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)
45569	<b>Fee:</b> \$677.60 <b>Benefit:</b> 75% = \$508.20
	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)
45570	Fee: \$914.95         Benefit: 75% = \$686.25         85% = \$833.25
	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.)
45572	<b>Fee:</b> \$291.70 <b>Benefit:</b> 75% = \$218.80 85% = \$247.95
	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.)
45575	<b>Fee:</b> \$720.20 <b>Benefit:</b> 75% = \$540.15 85% = \$638.50
	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.)
45578	<b>Fee:</b> \$834.05 <b>Benefit:</b> 75% = \$625.55
	FACIAL NERVE PALSY, excision of tissue for (Anaes.)
45581	<b>Fee:</b> \$276.80 <b>Benefit:</b> 75% = \$207.60 85% = \$235.30
	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.)
	(See para TN.8.8, TN.8.101 of explanatory notes to this Category)
45584	Fee: \$631.75         Benefit: 75% = \$473.85         85% = \$550.05           Extended Medicare Safety Net Cap: \$505.40
	Liposuction (suction assisted lipolysis) to one regional area, other than a service associated with a service to which item 31525 applies, if 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.)
45585	(See para TN.8.8, TN.8.101 of explanatory notes to this Category)         Fee: \$631.75       Benefit: 75% = \$473.85       85% = \$550.05         Extended Medicare Safety Net Cap: \$505.40
75505	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.)
45586	(See para TN.8.101 of explanatory notes to this Category) <b>Fee:</b> \$631.75 <b>Benefit:</b> 75% = \$473.85
	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.) (Assist.)
45587	(See para TN.8.102 of explanatory notes to this Category)

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$890.85Benefit: 75Extended Medicare Safety Net	% = \$668.15 85% = \$809.15 t <b>Cap:</b> \$712.70
	demonstrated that surgery is ind	wlifts and chinlift platysmaplasties), bilateral <i>where it can be</i> icated because of congenital conditions, disease or trauma (other than elective cosmetic surgery) (Anaes.) (Assist.)
45588	(See para TN.8.102 of explanatory r Fee: \$1,336.40 Benefit: 75	notes to this Category) 5% = \$1002.30
	ORBITAL CAVITY, reconstruc	tion of a wall or floor, with or without foreign implant (Anaes.) (Assist.)
45590	<b>Fee:</b> \$483.25 <b>Benefit:</b> 75	5% = \$362.45
	ORBITAL CAVITY, bone or ca entrapped orbital contents (Anae	rtilage graft to orbital wall or floor including reduction of prolapsed or es.) (Assist.)
45593	<b>Fee:</b> \$567.65 <b>Benefit:</b> 75	5% = \$425.75
	MAXILLA, total resection of (A	naes.) (Assist.)
45596	<b>Fee:</b> \$900.45 <b>Benefit:</b> 75	5% = \$675.35
	MAXILLA, total resection of bo	oth maxillae (Anaes.) (Assist.)
45597	<b>Fee:</b> \$1,205.40 <b>Benefit:</b> 75	5% = \$904.05
		both sides, including condylectomies where performed (Anaes.) (Assist.)
45599	<b>Fee:</b> \$936.55 <b>Benefit:</b> 75	5% = \$702.45 $85% = $854.85$
		order, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)
45602	<b>Fee:</b> \$699.45 <b>Benefit:</b> 75	5% = \$524.60
		egmental resection of, for tumours or cysts (Anaes.) (Assist.)
45605	<b>Fee:</b> \$587.60 <b>Benefit:</b> 75	5% = \$440.70
		econstruction with bone graft, not being a service associated with a
45608	<b>Fee:</b> \$827.30 <b>Benefit:</b> 75	5% = \$620.50
	MANDIBLE, condylectomy (Ar	naes.) (Assist.)
45611	<b>Fee:</b> \$473.75 <b>Benefit:</b> 75	5% = \$355.35
		S RECONSTRUCTION OF other than by direct suture only (Anaes.)
45614	Fee: \$587.60 Benefit: 75 Extended Medicare Safety Net	5% = \$440.70 85% = \$505.90 t <b>Cap:</b> \$470.10
	eyelid skin resting on lashes on s	VOF, for skin redundancy obscuring vision (as evidenced by upper straight ahead gaze), herniation of orbital fat in exophthalmos, facial rring, or the restoration of symmetry of contralateral upper eyelid in (Anaes.)
45 (17		5% = \$176.30 85% = \$199.80
45617	Extended Medicare Safety Net	-
45620	LOWEK EYELID, REDUCTIO	N OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or

T8. SUR	IRGICAL OPERATIONS 13. PLAS	TIC AND RECONSTRUCTIVE SURGERY
	posttraumatic scarring, or, in respect of 1 of these conditio contralateral lower eyelid (Anaes.)	ns, the restoration of symmetry of the
	(See para TN.8.103 of explanatory notes to this Category) <b>Fee:</b> \$326.05 <b>Benefit:</b> 75% = \$244.55 85% = \$277. <b>Extended Medicare Safety Net Cap:</b> \$260.85	15
	PTOSIS of eyelid (unilateral), correction of (Anaes.) (Assi	ist.)
45623	Fee: \$723.05         Benefit: 75% = \$542.30         85% = \$641.3           Extended Medicare Safety Net Cap: \$578.45	35
	PTOSIS of eyelid, correction of, where previous ptosis sur (Assist.)	gery has been performed on that side (Anaes.)
45624	Fee:         \$937.40         Benefit:         75% = \$703.05         85% = \$855.7           Extended Medicare Safety Net Cap:         \$749.95	70
	PTOSIS of eyelid, correction of eyelid height by revision of repair by levator resection or advancement, performed in t	1 7
45625	<b>Fee:</b> \$187.55 <b>Benefit:</b> 75% = \$140.70	
	ECTROPION OR ENTROPION, correction of (unilateral)	(Anaes.)
45626	<b>Fee:</b> \$326.05 <b>Benefit:</b> 75% = \$244.55 85% = \$277.	15
	SYMBLEPHARON, grafting for (Anaes.) (Assist.)	
45629	<b>Fee:</b> \$473.75 <b>Benefit:</b> 75% = \$355.35 85% = \$402.	70
	RHINOPLASTY, correction of lateral or alar cartilages fo	r correction of nasal obstruction (Anaes.)
45632	Fee: \$511.95         Benefit: 75% = \$384.00         85% = \$435.3           Extended Medicare Safety Net Cap: \$409.60	20
	RHINOPLASTY, correction of vault only, for correction of deformity (other than deformity resulting from previous el	
45635	Fee: \$587.60         Benefit: 75% = \$440.70         85% = \$505.5           Extended Medicare Safety Net Cap: \$470.10	90
13035	RHINOPLASTY, TOTAL, including correction of all bon nose, for correction of nasal obstruction or post-traumatic <i>elective cosmetic surgery)</i> , or both (H) (Anaes.)	
45638	(See para TN.8.104 of explanatory notes to this Category) <b>Fee:</b> \$1,014.05 <b>Benefit:</b> 75% = \$760.55	
	RHINOPLASTY, TOTAL, including correction of all bon nose, <i>where it can be demonstrated</i> that there is a need for deformity (H) (Anaes.)	
45639	(See para TN.8.104 of explanatory notes to this Category) <b>Fee:</b> \$1,014.05 <b>Benefit:</b> 75% = \$760.55	
	RHINOPLASTY involving nasal or septal cartilage graft, cartilage graft for correction of nasal obstruction or post-tr resulting from previous elective cosmetic surgery), or both	aumatic deformity (other than deformity
45641	<b>Fee:</b> \$1,082.90 <b>Benefit:</b> 75% = \$812.20	

T8. SUR	GICAL OPERATIO	DNS         13. PLASTIC AND RECONSTRUCTIVE SURGERY
		TOTAL, including correction of all bony and cartilaginous elements of the external ogenous bone or cartilage graft obtained from distant donor site, including obtaining
		asal obstruction or post-traumatic deformity (other than deformity resulting from cosmetic surgery), or both. (H) (Anaes.) (Assist.)
45644	Fee: \$1,279.45	<b>Benefit:</b> 75% = \$959.60
	CHOANAL ATRI	ESIA, repair of by puncture and dilatation (Anaes.)
45645	Fee: \$223.60	<b>Benefit:</b> 75% = \$167.70
	CHOANAL ATRI	ESIA - correction by open operation with bone removal (Anaes.) (Assist.)
45646	Fee: \$900.45	<b>Benefit:</b> 75% = \$675.35 85% = \$818.75
 		storation of 1 region, using autogenous bone or cartilage graft (not being a service to applies) (Anaes.) (Assist.)
45647	(See para TN.8.105 <b>Fee:</b> \$1,279.45	of explanatory notes to this Category) Benefit: 75% = \$959.60
		secondary revision of, for correction of nasal obstruction, post-traumatic deformity nity resulting from previous elective cosmetic surgery) or significant developmental )
45650	Fee: \$147.80	<b>Benefit:</b> 75% = \$110.85 85% = \$125.65
	RHINOPHYMA,	carbon dioxide laser or erbium laser excision-ablation of (Anaes.)
45652	Fee: \$356.35 Extended Medica	<b>Benefit:</b> 75% = \$267.30 85% = \$302.90 are <b>Safety Net Cap:</b> \$285.10
	RHINOPHYMA,	shaving of (Anaes.)
45653	Fee: \$356.35	<b>Benefit:</b> 75% = \$267.30 85% = \$302.90
	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Ass	
45656	Fee: \$502.25	<b>Benefit:</b> 75% = \$376.70 85% = \$426.95
		CAR OR SIMILAR DEFORMITY, correction of (Anaes.)
45659	Fee: \$521.25 Extended Medica	<b>Benefit:</b> 75% = \$390.95 85% = \$443.10 are Safety Net Cap: \$417.00
	grafts to form a fra congenital absence	A, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage amework, including the harvesting and sculpturing of the cartilage and its insertion, for e, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - ecialist in the practice of his or her specialty (Anaes.) (Assist.)
45660	Fee: \$2,878.75	<b>Benefit:</b> 75% = \$2159.10
	framework using c flaps and full thick	e, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage cartilage previously stored in abdominal wall, including the use of local skin and fascia cness skin graft to cover cartilage (second stage) - performed by a specialist in the
	practice of his or h	er specialty (Anaes.) (Assist.)

T8. SUF	GICAL OPERAT	TONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	CONGENITAL	ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.)
45662	Fee: \$701.30	<b>Benefit:</b> 75% = \$526.00
	LIP, EYELID O (Anaes.)	R EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures
45665	Fee: \$326.05	<b>Benefit:</b> 75% = \$244.55 85% = \$277.15
	VERMILIONE	CTOMY, by surgical excision (Anaes.)
45668	Fee: \$326.05	<b>Benefit:</b> 75% = \$244.55 85% = \$277.15
	VERMILIONE	CTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.)
45669	(See para TN.8.10 <b>Fee:</b> \$326.05	06 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$244.55 85% = \$277.15
		D RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.)
45671	Fee: \$834.05	<b>Benefit:</b> 75% = \$625.55 85% = \$752.35
	LIP OR EYELII (Anaes.)	D RECONSTRUCTION using full thickness flap (Abbe or similar), second stage
45674	Fee: \$242.55	<b>Benefit:</b> 75% = \$181.95 85% = \$206.20
	MACROCHEIL	IA or macroglossia, operation for (Anaes.) (Assist.)
45675	Fee: \$483.25	<b>Benefit:</b> 75% = \$362.45
	MACROSTOM	IA, operation for (Anaes.) (Assist.)
45676	Fee: \$575.30	<b>Benefit:</b> 75% = \$431.50
	CLEFT LIP, uni	lateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)
45677	Fee: \$541.35	<b>Benefit:</b> 75% = \$406.05
	CLEFT LIP, uni	lateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
45680	Fee: \$676.80	<b>Benefit:</b> 75% = \$507.60
	CLEFT LIP, bil	ateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)
45683	Fee: \$751.85	<b>Benefit:</b> 75% = \$563.90
	CLEFT LIP, bil	ateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
45686	Fee: \$887.50	<b>Benefit:</b> 75% = \$665.65
		adhesion procedure, unilateral or bilateral (Anaes.) (Assist.)
45689	Fee: \$261.75	<b>Benefit:</b> 75% = \$196.35
		tial revision, including minor flap revision alignment and adjustment, including revision e deformity if performed (Anaes.)
45692	Fee: \$300.75	<b>Benefit:</b> 75% = \$225.60 85% = \$255.65
		al revision, including major flap revision, muscle reconstruction and revision of major ty (Anaes.) (Assist.)
45695	Fee: \$488.75	<b>Benefit:</b> 75% = \$366.60

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	CLEFT LIP, primary columella lengthen	ing procedure, bilateral (Anaes.)
45698	<b>Fee:</b> \$458.75 <b>Benefit:</b> 75% = \$344	.10
	CLEFT LIP RECONSTRUCTION using (Assist.)	full thickness flap (Abbe or similar), first stage (Anaes.)
45701	<b>Fee:</b> \$827.30 <b>Benefit:</b> 75% = \$620	.50
	CLEFT LIP RECONSTRUCTION using	full thickness flap (Abbe or similar), second stage (Anaes.)
45704	<b>Fee:</b> \$300.75 <b>Benefit:</b> 75% = \$225	.60 85% = \$255.65
	CLEFT PALATE, primary repair (Anaes	.) (Assist.)
45707	<b>Fee:</b> \$781.95 <b>Benefit:</b> 75% = \$586	.50
	CLEFT PALATE, secondary repair, clos	ure of fistula using local flaps (Anaes.)
45710	<b>Fee:</b> \$488.75 <b>Benefit:</b> 75% = \$366	60
	CLEFT PALATE, secondary repair, leng	thening procedure (Anaes.) (Assist.)
45713	<b>Fee:</b> \$556.60 <b>Benefit:</b> 75% = \$417	.45
		of, including services to which item 45200, 45203 or 45239
45714	<b>Fee:</b> \$781.95 <b>Benefit:</b> 75% = \$586	.50
		CE, pharyngeal flap for, or pharyngoplasty for (Anaes.)
45716	<b>Fee:</b> \$781.95 <b>Benefit:</b> 75% = \$586	.50
	MANDIBLE OR MAXILLA, unilateral	osteotomy or osteectomy of, including transposition of nerves e same site and excluding services to which item 47933or
45720	(See para TN.8.107 of explanatory notes to th <b>Fee:</b> \$966.80 <b>Benefit:</b> 75% = \$725	
	and vessels and bone grafts taken from th	osteotomy or osteectomy of, including transposition of nerves be same site and stabilisation with fixation by wires, screws, scluding services to which item 47933 or 47936 apply (Anaes.)
45723	(See para TN.8.107 of explanatory notes to th <b>Fee:</b> \$1,090.35 <b>Benefit:</b> 75% = \$817	
		steotomy or osteectomy of, including transposition of nerves the same site, and excluding services to which item 47933 or
45726	(See para TN.8.107 of explanatory notes to th <b>Fee:</b> \$1,232.05 <b>Benefit:</b> 75% = \$924	
	and vessels and bone grafts taken from th	steotomy or osteectomy of, including transposition of nerves le same site and stabilisation with fixation by wires, screws, scluding services to which item 47933 or 47936 apply (Anaes.)
45729	(See para TN.8.107 of explanatory notes to th <b>Fee:</b> \$1,383.65 <b>Benefit:</b> 75% = \$103	

T8. SURGICAL OPERATIONS       13. PLASTIC AND RECONSTRUCTIVE SUI		13. PLASTIC AND RECONSTRUCTIVE SURGERY
		nies or osteectomies of, involving 3 or more such procedures on the res and vessels and bone grafts taken from the same site, and 33 or 47936 apply (Anaes.) (Assist.)
45731	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,402.70 <b>Benefit:</b> 75% = \$	
	the 1 jaw, including transposition of 1	omies or osteectomies of, involving 3 or more such procedures on herves and vessels and bone grafts taken from the same site and crews, plates or pins, or any combination, and excluding services to naes.) (Assist.)
45732	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,579.20 <b>Benefit:</b> 75% = \$	
		otomies or osteectomies of, involving 2 such procedures of each s and vessels and bone grafts taken from the same site, and 33 or 47936 apply (Anaes.) (Assist.)
45735	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,611.05 <b>Benefit:</b> 75% = 3	
	jaw, including transposition of nerves	otomies or osteectomies of, involving 2 such procedures of each s and vessels and bone grafts taken from the same site and crews, plates or pins, or any combination, and excluding services to naes.) (Assist.)
45738	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,812.40 <b>Benefit:</b> 75% = 3	
	such procedures of 1 jaw and 2 such	plex bilateral osteotomies or osteectomies of, involving 3 or more procedures of the other jaw, including genioplasty when performed ls and bone grafts taken from the same site, and excluding services (Anaes.) (Assist.)
45741	(See para TN.8.107 of explanatory notes Fee: \$1,772.30 Benefit: 75% = \$	
	such procedures of 1 jaw and 2 such and transposition of nerves and vesse	plex bilateral osteotomies or osteectomies of, involving 3 or more procedures of the other jaw, including genioplasty when performed ls and bone grafts taken from the same site and stabilisation with ns, or any combination, and excluding services to which item st.)
45744	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,992.70 <b>Benefit:</b> 75% = \$	
	such procedures of each jaw, includin	plex bilateral osteotomies or osteectomies of, involving 3 or more ng genioplasty (when performed) and transposition of nerves and e same site, and excluding services to which item 47933 or 47936
45747	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,933.55 <b>Benefit:</b> 75% = 3	to this Category) \$1450.20
45752	such procedures of each jaw, includir vessels and bone grafts taken from th	plex bilateral osteotomies or osteectomies of, involving 3 or more ag genioplasty when performed and transposition of nerves and e same site and stabilisation with fixation by wires, screws, plates uding services to which item 47933 or 47936 apply (Anaes.)

T8. SUF	GICAL OPERATIO	NS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(Assist.)		
	(See para TN.8.107 o <b>Fee:</b> \$2,165.75	f explanatory notes to this Category) Benefit: 75% = \$1624.35	
	III(Malar-Maxillary	EOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort <i>i</i> ), Le Fort III involving 3 or more osteotomies of the midface including transposition ls and bone grafts taken from the same site (Anaes.) (Assist.)	
45753	Fee: \$2,178.60	<b>Benefit:</b> 75% = \$1633.95 85% = \$2096.90	
	(Malar-Maxillary), nerves and vessels a	EOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III Le Fort III involving 3 or more osteotomies of the midface including transposition of and bone grafts taken from the same site and stabilisation with fixation by wires, ns, or any combination (Anaes.) (Assist.)	
45754	<b>Fee:</b> \$2,611.60	<b>Benefit:</b> 75% = \$1958.70	
-575-		IBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)	
45755	<b>Fee:</b> \$367.75	<b>Benefit:</b> 75% = \$275.85 85% = \$312.60	
10700		DIBULAR JOINT, arthroplasty (Anaes.) (Assist.)	
45758	Fee: \$658.05	<b>Benefit:</b> 75% = \$493.55	
13750	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)		
45761	(See para TN.8.108 o <b>Fee:</b> \$748.65	f explanatory notes to this Category) Benefit: 75% = \$561.50	
	HYPERTELORISM	A, correction of, intracranial (Anaes.) (Assist.)	
45767	Fee: \$2,511.65	<b>Benefit:</b> 75% = \$1883.75 85% = \$2429.95	
	HYPERTELORISM	A, correction of, subcranial (Anaes.) (Assist.)	
45770	Fee: \$1,923.90	<b>Benefit:</b> 75% = \$1442.95	
	TREACHER COLI grafts (Anaes.) (Ass	LINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone sist.)	
45773	Fee: \$1,753.40	<b>Benefit:</b> 75% = \$1315.05 85% = \$1671.70	
	ORBITAL DYSTC intracranial (Anaes.	PIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, ) (Assist.)	
45776	Fee: \$1,753.40	<b>Benefit:</b> 75% = \$1315.05	
	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)		
45779	Fee: \$1,289.15	<b>Benefit:</b> 75% = \$966.90	
	FRONTOORBITA	L ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)	
45782	Fee: \$985.70	<b>Benefit:</b> 75% = \$739.30 85% = \$904.00	
		F RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar frontoorbital advancement) (Anaes.) (Assist.)	
45785	Fee: \$1,668.10	<b>Benefit:</b> 75% = \$1251.10	

T8. SURGICAL OPERATIONS		DNS         13. PLASTIC AND RECONSTRUCTIVE SURGERY
		A, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, ique) (Anaes.) (Assist.)
45788	Fee: \$1,649.10	<b>Benefit:</b> 75% = \$1236.85
		YLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, esting of graft material (Anaes.) (Assist.)
45791	Fee: \$890.85	<b>Benefit:</b> 75% = \$668.15
		ATION PROCEDURE - extra-oral, implantation of titanium fixture, not for conduction hearing system device (Anaes.)
45794	Fee: \$503.85	<b>Benefit:</b> 75% = \$377.90 85% = \$428.30
		ATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone g system device (Anaes.)
45797	Fee: \$186.50	<b>Benefit:</b> 75% = \$139.90 85% = \$158.55
		ORAL AND MAXILLOFACIAL SURGERY
		OPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for es and not being a service associated with an operative procedure on the same day
45799	Fee: \$29.45	<b>Benefit:</b> 75% = \$22.10 85% = \$25.05
	operation), in the o subcutaneous tissu not being a service	C, ULCER OR SCAR, (other than a scar removed during the surgical approach at an aral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or ue or from mucous membrane, where the removal is by surgical excision and suture, to which item 45803 applies (Anaes.)
45801	(See para TN.8.109 <b>Fee:</b> \$126.90	of explanatory notes to this Category) Benefit: 75% = \$95.20 85% = \$107.90
	an operation), in the subcutaneous tissue	TS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at he oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or ie or from mucous membrane, where the removal is by surgical excision and suture, is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.)
45803	(See para TN.8.109 <b>Fee:</b> \$326.05	of explanatory notes to this Category) Benefit: 75% = \$244.55 85% = \$277.15
	operation), in the	, ULCER OR SCAR, (other than a scar removed during the surgical approach at an oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or ne or from mucous membrane (Anaes.)
45805	(See para TN.8.109 <b>Fee:</b> \$172.50	of explanatory notes to this Category) Benefit: $75\% = $129.40$ $85\% = $146.65$
	established by rad lining and tooth st ULCER OR SCAI and maxillofacial	Y (other than a cyst associated with a tooth or tooth fragment unless it has been iological examination that there is a minimum of 5mm separation between the cyst ructure or where a tumour or cyst has been proven by positive histopathology), R (other than a scar removed during the surgical approach at an operation), in the oral region, removal of, not being a service to which another item in this Subgroup applies, bone, or other deep tissue (Anaes.)
45807	(See para TN.8.109 <b>Fee:</b> \$246.50	of explanatory notes to this Category) Benefit: 75% = \$184.90 85% = \$209.55
45809	TUMOUR OR DE	EEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	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.)
	(See para TN.8.109 of explanatory notes to this Category)           Fee: \$371.50         Benefit: 75% = \$278.65         85% = \$315.80
	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)
45811	(See para TN.8.109 of explanatory notes to this Category)           Fee: \$502.25         Benefit: 75% = \$376.70         85% = \$426.95
	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.)
45813	(See para TN.8.109 of explanatory notes to this Category)           Fee: \$587.60         Benefit: 75% = \$440.70         85% = \$505.90
	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.)
45815	<b>Fee:</b> \$356.35 <b>Benefit:</b> 75% = \$267.30 85% = \$302.90
	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.)
45817	<b>Fee:</b> \$464.50 <b>Benefit:</b> 75% = \$348.40 85% = \$394.85
	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.)
45819	<b>Fee:</b> \$587.55 <b>Benefit:</b> 75% = \$440.70 85% = \$505.85
	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.)
45821	<b>Fee:</b> \$380.80 <b>Benefit:</b> 75% = \$285.60 85% = \$323.70
	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.)
45823	<b>Fee:</b> \$108.90 <b>Benefit:</b> 75% = \$81.70
	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)
45825	<b>Fee:</b> \$338.35 <b>Benefit:</b> 75% = \$253.80 85% = \$287.60
	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.)
45827	<b>Fee:</b> \$323.40 <b>Benefit:</b> 75% = \$242.55 85% = \$274.90
	MAXILLARY TUBEROSITY, reduction of (Anaes.)
45829	<b>Fee:</b> \$246.70 <b>Benefit:</b> 75% = \$185.05 85% = \$209.70
73027	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.)
15021	
45831	Fee: \$323.40         Benefit: 75% = \$242.55         85% = \$274.90           PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.)
45833	

T8. SUF	URGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$406.05	<b>Benefit:</b> 75% = \$304.55	85% = \$345.15	
	PAPILLARY H	YPERPLASIA OF THE PAI	LATE, removal of - more than 20 lesions (Anaes.) (Assist.)	
45835	Fee: \$503.85	<b>Benefit:</b> 75% = \$377.90	85% = \$428.30	
	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)			
45837	Fee: \$586.50	<b>Benefit:</b> 75% = \$439.90	85% = \$504.80	
		UTH LOWERING (Obwege graft when performed - unila	eser or similar procedure), including excision of muscle and teral (Anaes.) (Assist.)	
45839	Fee: \$586.50	<b>Benefit:</b> 75% = \$439.90	85% = \$504.80	
	ALVEOLAR RI	DGE AUGMENTATION w	ith bone or alloplast or both - unilateral (Anaes.) (Assist.)	
45841	Fee: \$473.65	<b>Benefit:</b> 75% = \$355.25	85% = \$402.65	
		DGE AUGMENTATION - 1 ndibular alveolar ridge regior	unilateral, insertion of tissue expanding device into a for (Anaes.) (Assist.)	
45843	Fee: \$290.50	<b>Benefit:</b> 75% = \$217.90	85% = \$246.95	
		e dentition following resection	tra-oral implantation of titanium fixture to facilitate n of part of the maxilla or mandible for benign or	
45845	Fee: \$503.85	<b>Benefit:</b> 75% = \$377.90	85% = \$428.30	
			xation of transmucosal abutment to fixtures placed nandible for benign or malignant tumours (Anaes.)	
45847	Fee: \$186.50	<b>Benefit:</b> 75% = \$139.90	85% = \$158.55	
		INUS, BONE GRAFT to flo ure), (unilateral) (Anaes.) (A	oor of maxillary sinus following elevation of mucosal lining assist.)	
45849	Fee: \$580.90	<b>Benefit:</b> 75% = \$435.70	85% = \$499.20	
			lation of, performed in the operating theatre of a hospital, to which another item in this Subgroup applies (Anaes.)	
45851	Fee: \$142.95	<b>Benefit:</b> 75% = \$107.25		
		OYLE and ASCENDING RA ting of graft material (Anaes	MUS in hemifacial microsomia, construction of, not .) (Assist.)	
45853	Fee: \$890.85	<b>Benefit:</b> 75% = \$668.15	85% = \$809.15	
	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.)			
45855	Fee: \$408.70	<b>Benefit:</b> 75% = \$306.55	85% = \$347.40	
	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatme of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.)		at joint, not being a service associated with any other	
45857	Fee: \$653.80	<b>Benefit:</b> 75% = \$490.35	90.35 85% = \$572.10	
	TEMPOROMAN			

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	Subgroup applies (Anaes.) (Assist.)			
	<b>Fee:</b> \$329.60 <b>Benefit:</b> 75% = \$247	7.20 85% = \$280.20		
	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.)			
45861	<b>Fee:</b> \$872.30 <b>Benefit:</b> 75% = \$654	4.25 85% = \$790.60		
	TEMPOROMANDIBULAR JOINT, ope with or without microsurgical techniques	en surgical exploration of, with condylectomy or condylotomy, (Anaes.) (Assist.)		
45863	<b>Fee:</b> \$967.00 <b>Benefit:</b> 75% = \$725	5.25 85% = \$885.30		
	ARTHROCENTESIS, irrigation of temp appropriate joint space(s) (Anaes.) (Assis	oromandibular joint after insertion of 2 cannuli into the st.)		
45865	<b>Fee:</b> \$290.50 <b>Benefit:</b> 75% = \$217	7.90 85% = \$246.95		
	TEMPOROMANDIBULAR JOINT, syn Subgroup applies (Anaes.) (Assist.)	ovectomy of, not being a service to which another item in this		
45867	<b>Fee:</b> \$312.30 <b>Benefit:</b> 75% = \$234	4.25 85% = \$265.50		
		en surgical exploration of, with or without meniscus or capsular ectomy when performed, with or without microsurgical		
45869	<b>Fee:</b> \$1,188.20 <b>Benefit:</b> 75% = \$891	1.15 85% = \$1106.50		
	TEMPOROMANDIBULAR JOINT, ope head surgery, with or without microsurgi	en surgical exploration of, with meniscus, capsular and condylar cal techniques (Anaes.) (Assist.)		
45871	<b>Fee:</b> \$1,338.45 <b>Benefit:</b> 75% = \$100	03.85 85% = \$1256.75		
		gery of, involving procedures to which items 45863, 45867, ng the use of tissue flaps, or cartilage graft, or allograft implants, o (Anaes.) (Assist.)		
45873	<b>Fee:</b> \$1,504.05 <b>Benefit:</b> 75% = \$112	28.05 85% = \$1422.35		
TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of c ligament or internal fixation, not being a service to which another item in this Subgroup (Assist.)				
45875	<b>Fee:</b> \$470.70 <b>Benefit:</b> 75% = \$353	8.05 85% = \$400.10		
	TEMPOROMANDIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)			
45877	<b>Fee:</b> \$470.70 <b>Benefit:</b> 75% = \$353	8.05 85% = \$400.10		
	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)			
45879	<b>Fee:</b> \$312.30 <b>Benefit:</b> 75% = \$234	4.25 85% = \$265.50		
	The treatment of a premalignant lesion or or carbon dioxide laser.	f the oral mucosa by a treatment using cryotherapy, diathermy		
45882	<b>Fee:</b> \$43.00 <b>Benefit:</b> 75% = \$32.	25 85% = \$36.55		
45885	Facial, mandibular or lingual artery or ve	in or artery and vein, ligation of, not being a service to which		

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	item 41707 applies (Anaes.) (Assist.	)
	<b>Fee:</b> \$443.70 <b>Benefit:</b> 75% =	\$332.80 85% = \$377.15
	FOREIGN BODY, in the oral and n techniques (Anaes.) (Assist.)	naxillofacial region, deep, removal of using interventional imaging
45888	<b>Fee:</b> \$413.55 <b>Benefit:</b> 75% =	\$310.20 85% = \$351.55
	SINGLE-STAGE LOCAL FLAP was (Assist.)	here indicated, repair to 1 defect, using temporalis muscle (Anaes.)
45891	<b>Fee:</b> \$602.45 <b>Benefit:</b> 75% =	\$451.85 85% = \$520.75
	FREE GRAFTING, in the oral and a (Anaes.)	maxillofacial region, (mucosa or split skin) of a granulating area
45894	<b>Fee:</b> \$204.70 <b>Benefit:</b> 75% =	\$153.55 85% = \$174.00
	ALVEOLAR CLEFT (congenital) u nasal fistulae and ridge augmentatio	nilateral, grafting of, including plastic closure of associated oro- n (Anaes.) (Assist.)
45897	<b>Fee:</b> \$1,069.10 <b>Benefit:</b> 75% =	\$801.85 85% = \$987.40
	MANDIBLE, fixation by intermaxil	lary wiring, excluding wiring for obesity
45900	<b>Fee:</b> \$241.15 <b>Benefit:</b> 75% =	\$180.90 85% = \$205.00
	PERIPHERAL BRANCHES OF TH (Assist.)	HE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.)
45939	<b>Fee:</b> \$447.10 <b>Benefit:</b> 75% =	\$335.35 85% = \$380.05
	MANDIBLE, treatment of a disloca	tion of, requiring open reduction (Anaes.)
45945	<b>Fee:</b> \$118.70 <b>Benefit:</b> 75% =	\$89.05 85% = \$100.90
	MAXILLA, unilateral or bilateral, the	reatment of fracture of, not requiring splinting
45975	(See para TN.8.110 of explanatory notes <b>Fee:</b> \$129.20 <b>Benefit:</b> 75% =	s to this Category) : \$96.90 85% = \$109.85
	MANDIBLE, treatment of fracture of	of, not requiring splinting
45978	(See para TN.8.110 of explanatory notes <b>Fee:</b> \$157.85 <b>Benefit:</b> 75% =	s to this Category) \$118.40 85% = \$134.20
43978		fracture of, not requiring surgical reduction
45981	(See para TN.8.110 of explanatory notes	
	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.)	
45984	(See para TN.8.110 of explanatory notes <b>Fee:</b> \$616.65 <b>Benefit:</b> 75% =	s to this Category) \$462.50
	MANDIBLE, treatment of a compli- requiring open reduction not involvi	cated fracture of, involving viscera, blood vessels or nerves, ng plate(s) (Anaes.) (Assist.)
45987	(See para TN.8.110 of explanatory notes <b>Fee:</b> \$616.65 <b>Benefit:</b> 75% =	s to this Category) \$462.50 85% = \$534.95

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	MAXILLA, treatment of a complication open reduction involving the use of	ted fracture of, involving viscera, blood vessels or nerves requiring plate(s) (Anaes.) (Assist.)		
45990	(See para TN.8.110 of explanatory notes <b>Fee:</b> \$842.25 <b>Benefit:</b> 75% =	to this Category) \$631.70		
	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.)			
45993	(See para TN.8.110 of explanatory notes <b>Fee:</b> \$842.25 <b>Benefit:</b> 75% =	to this Category) \$631.70		
	MANDIBLE, treatment of a closed	fracture of, involving a joint surface (Anaes.)		
45996	(See para TN.8.110 of explanatory notes <b>Fee:</b> \$238.80 <b>Benefit:</b> 75% =	to this Category) \$179.10		
T8. SUF	GICAL OPERATIONS	14. HAND SURGERY		
	Group T8. Surgical Operations			
		Subgroup 14. Hand Surgery		
	Note: Items 46300 to 46534 are rest	ricted to surgery on the hand/s.		
	INTER-PHALANGEAL JOINT or synovectomy if performed (Anaes.)	METACARPOPHALANGEAL JOINT, arthrodesis of, with (Assist.)		
46300	<b>Fee:</b> \$338.40 <b>Benefit:</b> 75% =	\$253.80		
	CARPOMETACARPAL JOINT, ar	throdesis of, with synovectomy if performed (Anaes.) (Assist.)		
46303	<b>Fee:</b> \$376.10 <b>Benefit:</b> 75% =	\$282.10		
		IETACARPOPHALANGEAL JOINT, interposition arthroplasty of lignment on the 1 ray (Anaes.) (Assist.)		
46306	<b>Fee:</b> \$526.50 <b>Benefit:</b> 75% =	\$394.90		
		METACARPOPHALANGEAL JOINT - volar plate arthroplasty for n transfers or realignment on the 1 ray (Anaes.) (Assist.)		
46307	<b>Fee:</b> \$526.50 <b>Benefit:</b> 75% =	\$394.90		
	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.)			
46309	<b>Fee:</b> \$526.50 <b>Benefit:</b> 75% =	\$394.90		
	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.)			
46312	<b>Fee:</b> \$676.95 <b>Benefit:</b> 75% =	\$507.75		
	INTERPHALANGEAL JOINT or M arthroplasty or hemiarthroplasty of,	IETACARPOPHALANGEAL JOINT, total replacement		

T8. SUF	GICAL OPERATION	DNS 14. HAND SURGERY		
	3 joints (Anaes.) (	Assist.)		
	Fee: \$902.55	<b>Benefit:</b> 75% = \$676.95		
		GEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement niarthroplasty of, including associated synovectomy, tendon transfer or realignment - Assist.)		
46318	Fee: \$1,128.25	<b>Benefit:</b> 75% = \$846.20		
		GEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement niarthroplasty of, including associated synovectomy, tendon transfer or realignment - Anaes.) (Assist.)		
46321	Fee: \$1,353.90	<b>Benefit:</b> 75% = \$1015.45 85% = \$1272.20		
		REPLACEMENT ARTHROPLASTY including associated tendon transfer or performed (Anaes.) (Assist.)		
46324	Fee: \$807.35	<b>Benefit:</b> 75% = \$605.55		
		REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or cluding associated tendon transfer or realignment when performed (Anaes.) (Assist.)		
46325	Fee: \$842.50	<b>Benefit:</b> 75% = \$631.90		
	INTER-PHALAN	GEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.)		
46327	Fee: \$203.15	<b>Benefit:</b> 75% = \$152.40 85% = \$172.70		
		GEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular out arthrotomy (Anaes.) (Assist.)		
46330	Fee: \$346.10	<b>Benefit:</b> 75% = \$259.60		
	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.)			
46333	Fee: \$564.05	<b>Benefit:</b> 75% = \$423.05		
		GEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, ebridement of, not being a service associated with any procedure related to that joint		
46336	Fee: \$263.30	<b>Benefit:</b> 75% = \$197.50 85% = \$223.85		
	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Ass			
46339	Fee: \$466.20	<b>Benefit:</b> 75% = \$349.65 85% = \$396.30		
	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectom (Anaes.) (Assist.)			
46342	Fee: \$466.20	<b>Benefit:</b> 75% = \$349.65		
		JLNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous accision of distal ulna, when performed (Anaes.) (Assist.)		
46345	Fee: \$564.05	<b>Benefit:</b> 75% = \$423.05		
	DIGIT, synovecto	my of flexor tendon or tendons - 1 digit (Anaes.)		
	Fee: \$244.45	<b>Benefit:</b> 75% = \$183.35 85% = \$207.80		

T8. SUF	RGICAL OPERA	IONS 14. HAND SURGERY	
	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.)		
46351	Fee: \$364.80	<b>Benefit:</b> 75% = \$273.60	
	DIGIT, synoved	omy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.)	
46354	Fee: \$488.85	<b>Benefit:</b> 75% = \$366.65	
	DIGIT, synoved	omy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.)	
46357	Fee: \$609.20	<b>Benefit:</b> 75% = \$456.90	
	DIGIT, synoved	omy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.)	
46360	Fee: \$733.35	<b>Benefit:</b> 75% = \$550.05	
	TENDON SHE (Anaes.)	ATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS	
46363	Fee: \$210.60	<b>Benefit:</b> 75% = \$157.95 85% = \$179.05	
	DUPUYTREN'	CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.)	
46366	Fee: \$127.90	<b>Benefit:</b> 75% = \$95.95 85% = \$108.75	
	DUPUYTREN'	CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.)	
46369	Fee: \$210.60	<b>Benefit:</b> 75% = \$157.95 85% = \$179.05	
	DUPUYTREN' (Anaes.) (Assist	CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand )	
46372	Fee: \$427.95	<b>Benefit:</b> 75% = \$321.00 85% = \$363.80	
	DUPUYTREN' hand (Anaes.) (	CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 ssist.)	
46375	Fee: \$507.70	<b>Benefit:</b> 75% = \$380.80 85% = \$431.55	
		CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of Anaes.) (Assist.)	
46378	Fee: \$676.95	<b>Benefit:</b> 75% = \$507.75	
	INTER-PHALA Dupuytren's Co	NGEAL JOINT, joint capsule release when performed in conjunction with operation for tracture - each procedure (Anaes.) (Assist.)	
46381	Fee: \$300.80	<b>Benefit:</b> 75% = \$225.60	
	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.)		
46384	Fee: \$300.80	<b>Benefit:</b> 75% = \$225.60	
_		CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - urrence in that ray (Anaes.) (Assist.)	
46387	Fee: \$620.60	<b>Benefit:</b> 75% = \$465.45 85% = \$538.90	
		CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - urrence in those rays (Anaes.) (Assist.)	
46390	Fee: \$827.50	<b>Benefit:</b> 75% = \$620.65	

T8. SUR	GICAL OPERAT	IONS	14. HAND SURGERY	
	DUPUYTREN'S CONTRACTURE, fasciectomy f			
	nerves - operatio	on for recurrence in those rays (Anaes.) (Assis	st.)	
46393	Fee: \$959.00	<b>Benefit:</b> 75% = \$719.25		
		METACARPAL OF THE HAND, osteotomy 933 or 47936 apply (Anaes.) (Assist.)	y or osteectomy of, and excluding services	
46396	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20 85% = \$280.20		
	PHALANX OR (Assist.)	METACARPAL OF THE HAND, osteotomy	y of, with internal fixation (Anaes.)	
46399	Fee: \$517.80	<b>Benefit:</b> 75% = \$388.35		
	PHALANX or M graft material (A	IETACARPAL, bone grafting of, for pseudat naes.) (Assist.)	rthrosis (non-union), including obtaining of	
46402	Fee: \$517.80	<b>Benefit:</b> 75% = \$388.35		
		IETACARPAL, bone grafting of, for pseudat uding obtaining of graft material (Anaes.) (A		
46405	Fee: \$631.90	<b>Benefit:</b> 75% = \$473.95		
	TENDON, recor	nstruction of, by tendon graft (Anaes.) (Assist	)	
46408	Fee: \$692.00	<b>Benefit:</b> 75% = \$519.00		
	FLEXOR TEND	OON PULLEY, reconstruction of, by graft (A	naes.) (Assist.)	
46411	Fee: \$406.15	<b>Benefit:</b> 75% = \$304.65		
		ENDON PROSTHESIS, INSERTION OF, in	preparation for tendon grafting (Anaes.)	
46414	Fee: \$526.40	<b>Benefit:</b> 75% = \$394.80 85% = \$447.45		
	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.)			
46417	Fee: \$488.85	<b>Benefit:</b> 75% = \$366.65		
		NDON OF HAND OR WRIST, primary repa	air of, each tendon (Anaes.)	
46420	Fee: \$204.60	<b>Benefit:</b> 75% = \$153.45 85% = \$173.95		
40420		NDON OF HAND OR WRIST, secondary re	epair of, each tendon (Anaes.) (Assist.)	
46423	Fee: \$327.15			
40423	Fee: \$327.15Benefit: 75% = \$245.4085% = \$278.10FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon			
	(Anaes.) (Assist.)			
46426	<b>Fee:</b> \$338.40	<b>Benefit:</b> 75% = \$253.80		
	FLEXOR TENE (Anaes.) (Assist	OON OF HAND OR WRIST, secondary repair	ir of, proximal to A1 pulley, each tendon	
46429	Fee: \$413.65	<b>Benefit:</b> 75% = \$310.25 85% = \$351.65		
		OON OF HAND, primary repair of, distal to A	A1 pulley, each tendon (Anaes.) (Assist.)	
	Fee: \$451.35	<b>Benefit:</b> 75% = \$338.55		

T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY		
	FLEXOR TENI	ON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)		
46435	Fee: \$526.50	<b>Benefit:</b> 75% = \$394.90		
	MALLET FING	ER, closed pin fixation of (Anaes.)		
46438	Fee: \$135.45	<b>Benefit:</b> 75% = \$101.60 85% = \$115.15		
	MALLET FING	ER, open repair of, including pin fixation when performed (Anaes.) (Assist.)		
46441	Fee: \$327.15	<b>Benefit:</b> 75% = \$245.40 85% = \$278.10		
		ER with intra articular fracture involving more than one third of base of terminal eduction (Anaes.) (Assist.)		
46442	Fee: \$280.85	<b>Benefit:</b> 75% = \$210.65		
	BOUTONNIER	E DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.)		
46444	Fee: \$488.85	<b>Benefit:</b> 75% = \$366.65		
	BOUTONNIER	E DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.)		
46447	Fee: \$609.20	<b>Benefit:</b> 75% = \$456.90		
	EXTENSOR TE	NDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.)		
46450	Fee: \$225.70	<b>Benefit:</b> 75% = \$169.30		
	FLEXOR TENI	ON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.)		
46453	Fee: \$376.10	<b>Benefit:</b> 75% = \$282.10		
	FINGER, percut	aneous tenotomy of (Anaes.)		
46456	Fee: \$97.80	<b>Benefit:</b> 75% = \$73.35 85% = \$83.15		
	OPERATION for	r OSTEOMYELITIS on distal phalanx (Anaes.)		
46459	Fee: \$188.05	<b>Benefit:</b> 75% = \$141.05 85% = \$159.85		
	OPERATION fo (Assist.)	r OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.)		
46462	Fee: \$300.80	<b>Benefit:</b> 75% = \$225.60 85% = \$255.70		
	AMPUTATION	of a supernumerary complete digit (Anaes.)		
46464	Fee: \$225.70	<b>Benefit:</b> 75% = \$169.30 85% = \$191.85		
		of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and sue cover (Anaes.)		
46465	Fee: \$225.70	<b>Benefit:</b> 75% = \$169.30 85% = \$191.85		
	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.)			
46468	Fee: \$394.90	<b>Benefit:</b> 75% = \$296.20		
	AMPUTATION tissue cover (An	of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)		
46471	Fee: \$564.05	<b>Benefit:</b> 75% = \$423.05 85% = \$482.35		

T8. SUF	RGICAL OPERATI	ONS	14. HAND SURGERY
	AMPUTATION tissue cover (Ana	· 1	bed, involving section of bone or joint and requiring soft
46474	Fee: \$733.35	<b>Benefit:</b> 75% = \$550.05	
	AMPUTATION tissue cover (Ana	-	bed, involving section of bone or joint and requiring soft
46477	Fee: \$902.55	<b>Benefit:</b> 75% = \$676.95	
		of SINGLE DIGIT, proximal tue cover, including metacarpal	o nail bed, involving section of bone or joint and (Anaes.) (Assist.)
46480	Fee: \$376.10	<b>Benefit:</b> 75% = \$282.10 85	5% = \$319.70
	REVISION of AN	MPUTATION STUMP to prove	ide adequate soft tissue cover (Anaes.) (Assist.)
46483	Fee: \$300.80	<b>Benefit:</b> 75% = \$225.60 85	5% = \$255.70
		rate reconstruction of nail bed l of a hospital (Anaes.)	aceration using magnification, undertaken in the
46486	Fee: \$225.70	<b>Benefit:</b> 75% = \$169.30	
		ndary exploration and accurate operating theatre of a hospital	repair of nail bed deformity using magnification, (Anaes.) (Assist.)
46489	Fee: \$263.30	<b>Benefit:</b> 75% = \$197.50	
		E OF DIGITS OF HAND, flexe cutaneous tissue (Anaes.) (Assi	or or extensor, correction of, involving tissues deeper ist.)
46492	Fee: \$361.05	<b>Benefit:</b> 75% = \$270.80	
	GANGLION OF in this Group app		a service associated with a service to which another item
46494	Fee: \$219.95	<b>Benefit:</b> 75% = \$165.00 85	5% = \$187.00
		MUCOUS CYST OF DISTAL which item 30107 applies (Ana	DIGIT, excision of, other than a service associated es.)
46495	Fee: \$203.15	<b>Benefit:</b> 75% = \$152.40 85	5% = \$172.70
		FLEXOR TENDON SHEATH tem 30107 applies (Anaes.)	, excision of, other than a service associated with a
46498	Fee: \$219.95	<b>Benefit:</b> 75% = \$165.00 85	<b>5</b> % = \$187.00
	GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a serv which item 30107 applies (Anaes.) (Assist.)		ision of, other than a service associated with a service to
46500	Fee: \$263.30	<b>Benefit:</b> 75% = \$197.50 85	5% = \$223.85
GANGLION OF VOLAR WRIST JOINT, excision of, other than a service assoc which item 30107 applies (Anaes.) (Assist.)		ion of, other than a service associated with a service to	
46501	Fee: \$329.20	<b>Benefit:</b> 75% = \$246.90 85	i% = \$279.85
		ANGLION OF DORSAL WRI which item 30107 applies (Ana	ST JOINT, excision of, other than a service associated es.) (Assist.)
46502	Fee: \$302.95	<b>Benefit:</b> 75% = \$227.25 85	1% — \$257 55

T8. SUF	RGICAL OPERAT	ONS	14. HAND SURGERY
		ANGLION OF VOLAR WRIST JOINT, excision which item 30107 applies (Anaes.) (Assist.)	on of, other than a service associated
46503	Fee: \$378.40	<b>Benefit:</b> 75% = \$283.80 85% = \$321.65	
	NEUROVASCU	LAR ISLAND FLAP, for pulp innervation (Ana	nes.) (Assist.)
46504	Fee: \$1,105.55	<b>Benefit:</b> 75% = \$829.20 85% = \$1023.85	
	DIGIT OR RAY	, transposition or transfer of, on vascular pedicle	e, complete procedure (Anaes.) (Assist.)
46507	Fee: \$1,286.20	<b>Benefit:</b> 75% = \$964.65	
	MACRODACTY	LY, surgical reduction of enlarged elements - e	ach digit (Anaes.) (Assist.)
46510	Fee: \$351.00	<b>Benefit:</b> 75% = \$263.25	
	DIGITAL NAIL (Anaes.)	OF FINGER OR THUMB, removal of, not beir	ng a service to which item 46516 applies
46513	Fee: \$56.50	<b>Benefit:</b> 75% = \$42.40 85% = \$48.05	
	DIGITAL NAIL	OF FINGER OR THUMB, removal of, in the o	perating theatre of a hospital (Anaes.)
46516	Fee: \$112.85	<b>Benefit:</b> 75% = \$84.65	
	MIDDLE PALM aftercare) (Anaes	AR, THENAR OR HYPOTHENAR SPACES ( .)	DF HAND, drainage of (excluding
46519	Fee: \$141.25	<b>Benefit:</b> 75% = \$105.95 85% = \$120.10	
	FLEXOR TEND (Anaes.) (Assist.)	ON SHEATH OF FINGER OR THUMB, open	operation and drainage for infection
46522	Fee: \$421.20	<b>Benefit:</b> 75% = \$315.90	
		FECTION, PARONYCHIA OF HAND, incision tal, not being a service to which another item in	
46525	Fee: \$56.50	<b>Benefit:</b> 75% = \$42.40 85% = \$48.05	
		AIL OF FINGER OR THUMB, wedge resection and portion of the nail bed (Anaes.)	n for, including removal of segment of
46528	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85% = \$144.10	
		AIL OF FINGER OR THUMB, partial resection ision of nail bed (Anaes.)	n of nail, including phenolisation but
46531	Fee: \$85.15	<b>Benefit:</b> 75% = \$63.90 85% = \$72.40	
	NAIL PLATE IN	IJURY OR DEFORMITY, radical excision of na	ail germinal matrix (Anaes.)
46534	Fee: \$235.50	<b>Benefit:</b> 75% = \$176.65 85% = \$200.20	
T8. SUI	RGICAL OPERAT	ONS	15. ORTHOPAEDIC
	Group T8. Surgi	cal Operations	
		Subgroup 15. Orthopaed	lic

T8. SUF	GICAL OPERA	TIONS 15. ORTHOPAEDIC	
		TREATMENT OF DISLOCATIONS	
	MANDIBLE, tı	eatment of dislocation of, by closed reduction (Anaes.)	
47000	Fee: \$70.65	<b>Benefit:</b> 75% = \$53.00 85% = \$60.10	
	CLAVICLE, tre	eatment of dislocation of, by closed reduction (Anaes.)	
47003	Fee: \$84.80	<b>Benefit:</b> 75% = \$63.60 85% = \$72.10	
	CLAVICLE, tre	eatment of dislocation of, by open reduction (Anaes.)	
47006	Fee: \$170.25	<b>Benefit:</b> 75% = \$127.70 85% = \$144.75	
	SHOULDER, tr item 47012 app	reatment of dislocation of, requiring general anaesthesia, not being a service to which lies (Anaes.)	
47009	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85% = \$144.10	
	SHOULDER, tr (Assist.)	reatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.)	
47012	Fee: \$338.85	<b>Benefit:</b> 75% = \$254.15	
	SHOULDER, tr	reatment of dislocation of, not requiring general anaesthesia	
47015	Fee: \$84.80	<b>Benefit:</b> 75% = \$63.60 85% = \$72.10	
	ELBOW, treatm	nent of dislocation of, by closed reduction (Anaes.)	
47018	Fee: \$197.60	<b>Benefit:</b> 75% = \$148.20 85% = \$168.00	
	ELBOW, treatm	nent of dislocation of, by open reduction (Anaes.) (Assist.)	
47021	Fee: \$263.60	<b>Benefit:</b> 75% = \$197.70	
		R JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not associated with fracture or dislocation in the same region (Anaes.)	
47024	Fee: \$197.60	<b>Benefit:</b> 75% = \$148.20 85% = \$168.00	
		R JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not associated with fracture or dislocation in the same region (Anaes.) (Assist.)	
47027	Fee: \$263.60	<b>Benefit:</b> 75% = \$197.70	
	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)		
47030	Fee: \$197.60	<b>Benefit:</b> 75% = \$148.20 85% = \$168.00	
		ARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of oy open reduction (Anaes.) (Assist.)	
47033	Fee: \$263.60	<b>Benefit:</b> 75% = \$197.70 85% = \$224.10	
	INTERPHALA	NGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	
47036	Fee: \$84.80	<b>Benefit:</b> 75% = \$63.60 85% = \$72.10	
	INTERPHALA	NGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)	
47039	Fee: \$112.85	<b>Benefit:</b> 75% = \$84.65 85% = \$95.95	

T8. SUF	GICAL OPERA	TIONS	15. ORTHOPAEDIC	
	METACARPO	PHALANGEAL JOINT, treatment of dislocation of, by closed r	reduction (Anaes.)	
47042	Fee: \$112.85	<b>Benefit:</b> 75% = \$84.65 85% = \$95.95		
	METACARPO	PHALANGEAL JOINT, treatment of dislocation of, by open rea	duction (Anaes.)	
47045	Fee: \$150.75	<b>Benefit:</b> 75% = \$113.10 85% = \$128.15		
	HIP, treatment of dislocation of, by closed reduction (Anaes.)			
47048	Fee: \$324.80	<b>Benefit:</b> 75% = \$243.60 85% = \$276.10		
	HIP, treatment	of dislocation of, by open reduction (Anaes.) (Assist.)		
47051	Fee: \$432.95	<b>Benefit:</b> 75% = \$324.75		
	KNEE, treatme	ent of dislocation of, by closed reduction (Anaes.) (Assist.)		
47054	Fee: \$324.80	<b>Benefit:</b> 75% = \$243.60 85% = \$276.10		
	PATELLA, trea	atment of dislocation of, by closed reduction (Anaes.)		
47057	Fee: \$127.00	<b>Benefit:</b> 75% = \$95.25 85% = \$107.95		
	PATELLA, trea	atment of dislocation of, by open reduction (Anaes.)		
47060	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85% = \$144.10		
	ANKLE or TA	RSUS, treatment of dislocation of, by closed reduction (Anaes.)		
47063	Fee: \$254.20	<b>Benefit:</b> 75% = \$190.65 85% = \$216.10		
	ANKLE or TA	RSUS, treatment of dislocation of, by open reduction (Anaes.) (Anaes.)	Assist.)	
47066	Fee: \$338.85	<b>Benefit:</b> 75% = \$254.15		
	TOE, treatment	t of dislocation of, by closed reduction (Anaes.)		
47069	Fee: \$70.65	<b>Benefit:</b> 75% = \$53.00 85% = \$60.10		
	TOE, treatment	t of dislocation of, by open reduction (Anaes.)		
47072	Fee: \$94.00	<b>Benefit:</b> 75% = \$70.50 85% = \$79.90		
		TREATMENT OF FRACTURES		
	Phalanx, middle or proximal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47304, 47307, 47310, 47313, 47316 or 47319 (Anaes.)			
47301	(See para TN.8.1 <b>Fee:</b> \$86.80	24 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$65.10 85% = \$73.80		
	Metacarpal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47301, 47307, 47310, 47313, 47316 or 47319 (Anaes.)			
47304	(See para TN.8.1 <b>Fee:</b> \$98.90	24 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$74.20		
	Phalanx or meta (Anaes.) (Assis	acarpal, treatment of fracture of, by closed reduction with percut	aneous K wire fixation	
47307	(See para TN.8.1 <b>Fee:</b> \$200.00	24 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$150.00		

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	Phalanx or metacarpal, treatment of fracture of, by open reduction with fixa	tion (Anaes.) (Assist.)
47310	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$330.00 <b>Benefit:</b> 75% = \$247.50	
	Phalanx or metacarpal, treatment of intra articular fracture of, by closed red wire fixation (Anaes.) (Assist.)	uction with percutaneous K
47313	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$320.00 <b>Benefit:</b> 75% = \$240.00	
	Phalanx or metacarpal, treatment of intra articular fracture of, by open reduction provided on the same occasion as a service to which item 47319 applies (An	
47316	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$635.00 <b>Benefit:</b> 75% = \$476.25	
	Middle phalanx, proximal end, treatment of intra articular fracture of, by op not provided on the same occasion as a service to which item 47316 applies	
47319	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$650.00 <b>Benefit:</b> 75% = \$487.50	
	CARPUS (excluding scaphoid), treatment of fracture of, not being a service (Anaes.)	e to which item 47351 applies
47348	<b>Fee:</b> \$94.00 <b>Benefit:</b> 75% = \$70.50 85% = \$79.90	
	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction	(Anaes.)
47351	<b>Fee:</b> \$235.50 <b>Benefit:</b> 75% = \$176.65 85% = \$200.20	
	CARPAL SCAPHOID, treatment of fracture of, not being a service to whic (Anaes.)	h item 47357 applies
47354	<b>Fee:</b> \$169.50 <b>Benefit:</b> 75% = \$127.15 85% = \$144.10	
	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.)	) (Assist.)
47357	<b>Fee:</b> \$376.55 <b>Benefit:</b> 75% = \$282.45 85% = \$320.10	
	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by than a service associated with a service to which item 47362, 47364, 47367.	
47361	(See para TN.8.124 of explanatory notes to this Category)           Fee: \$131.85         Benefit: 75% = \$98.90         85% = \$112.10	
	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, by general or major regional anaesthesia, but excluding local infiltration, other with a service to which item 47361, 47364, 47367, 47370 or 47373 applies	than a service associated
47362	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$197.60 <b>Benefit:</b> 75% = \$148.20 85% = \$168.00	
	Radius or ulna, distal end of, not involving joint surface, treatment of fractu fixation, other than a service associated with a service to which item 47361 (Assist.)	
47364	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$280.00 <b>Benefit:</b> 75% = \$210.00	
47367	Radius, distal end of, treatment of fracture of, by closed reduction with perc	cutaneous fixation, other than

T8. SUF	RGICAL OPERAT	IONS	15. ORTHOPAEDIC
	a service associa	ted with a service to which item 47361	or 47362 applies (Anaes.) (Assist.)
	(See para TN.8.12 <b>Fee:</b> \$223.60	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$167.70	
		d of, treatment of intra articular fracture d with a service to which item 47361 or	of, by open reduction with fixation, other than a 47362 applies (Anaes.) (Assist.)
47370	(See para TN.8.12 <b>Fee:</b> \$406.00	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$304.50	
		of, treatment of intra articular fracture o d with a service to which item 47361 or	f, by open reduction with fixation, other than a 47362 applies (Anaes.) (Assist.)
47373	(See para TN.8.12 <b>Fee:</b> \$290.00	4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$217.50	
	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.)		
47378	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85% = \$14	4.10
	RADIUS OR UI theatre of a hosp		by closed reduction undertaken in the operating
47381	Fee: \$254.20	<b>Benefit:</b> 75% = \$190.65	
	RADIUS OR UI	LNA, shaft of, treatment of fracture of, b	by open reduction (Anaes.) (Assist.)
47384	Fee: \$338.85	<b>Benefit:</b> 75% = \$254.15	
	ulnar joint or pro	LNA, shaft of, treatment of fracture of, in oximal radio-humeral joint (Galeazzi or e operating theatre of a hospital (Anaes.)	
47385	Fee: \$291.75	<b>Benefit:</b> 75% = \$218.85	
	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 interna fixation (Anaes.) (Assist.)		
47386	Fee: \$470.70	<b>Benefit:</b> 75% = \$353.05	
		ULNA, shafts of, treatment of fracture o 0 or 47393 applies (Anaes.) (Assist.)	f, by cast immobilisation, not being a service to
47387	Fee: \$272.95	<b>Benefit:</b> 75% = \$204.75 85% = \$23	2.05
	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)		f, by closed reduction undertaken in the
47390	Fee: \$409.55	<b>Benefit:</b> 75% = \$307.20	
	RADIUS AND U	ULNA, shafts of, treatment of fracture o	f, by open reduction (Anaes.) (Assist.)
47393	Fee: \$546.00	<b>Benefit:</b> 75% = \$409.50	
			vice to which item 47399 applies (Anaes.)
47396	Fee: \$188.20	<b>Benefit:</b> 75% = \$141.15 85% = \$16	0.00
47399		treatment of fracture of, by open reducti	

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45
	OLECRANON, tendon (Anaes.)	treatment of fracture of, involving excision of olecranon fragment and reimplantation of (Assist.)
47402	Fee: \$282.35	<b>Benefit:</b> 75% = \$211.80 85% = \$240.00
	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.)	
47405	Fee: \$188.20	<b>Benefit:</b> 75% = \$141.15 85% = \$160.00
		ent of fracture of head or neck of, open reduction of, including internal fixation and erformed (Anaes.) (Assist.)
47408	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45
	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.)	
47411	Fee: \$112.85	<b>Benefit:</b> 75% = \$84.65 85% = \$95.95
	HUMERUS, trea	atment of fracture of tuberosity of, by open reduction (Anaes.)
47414	Fee: \$226.00	<b>Benefit:</b> 75% = \$169.50 85% = \$192.10
	HUMERUS, trea reduction (Anaes	attment of fracture of tuberosity of, and associated dislocation of shoulder, by closed s.) (Assist.)
47417	Fee: \$263.60	<b>Benefit:</b> 75% = \$197.70 85% = \$224.10
	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder reduction (Anaes.) (Assist.)	
47420	Fee: \$517.80	<b>Benefit:</b> 75% = \$388.35
	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 474 47432 applies (Anaes.)	
47423	Fee: \$216.50	<b>Benefit:</b> 75% = \$162.40 85% = \$184.05
	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	
47426	Fee: \$324.80	<b>Benefit:</b> 75% = \$243.60
	HUMERUS, pro	ximal, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47429	Fee: \$432.95	<b>Benefit:</b> 75% = \$324.75
	HUMERUS, pro	ximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)
47432	Fee: \$541.30	<b>Benefit:</b> 75% = \$406.00
	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)	
47435	Fee: \$414.25	<b>Benefit:</b> 75% = \$310.70 85% = \$352.15
	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.)	
47438	Fee: \$659.15	<b>Benefit:</b> 75% = \$494.40
47441	HUMERUS, pro	ximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by

T8. SUF		TIONS 15. ORTHOPAEDIC
	open reduction	(Anaes.) (Assist.)
	Fee: \$823.75	<b>Benefit:</b> 75% = \$617.85
	HUMERUS, sh (Anaes.)	aft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies
47444	Fee: \$226.00	<b>Benefit:</b> 75% = \$169.50 85% = \$192.10
	HUMERUS, sh a hospital (Anae	aft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of es.)
47447	Fee: \$338.85	<b>Benefit:</b> 75% = \$254.15
	HUMERUS, sh	aft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)
47450	Fee: \$451.95	<b>Benefit:</b> 75% = \$339.00
	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.)	
47451	Fee: \$544.80	<b>Benefit:</b> 75% = \$408.60
	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.)	
47453	Fee: \$263.60	<b>Benefit:</b> 75% = \$197.70 85% = \$224.10
	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertake in the operating theatre of a hospital (Anaes.)	
47456	Fee: \$395.50	<b>Benefit:</b> 75% = \$296.65
	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	
47459	Fee: \$527.25	<b>Benefit:</b> 75% = \$395.45
	CLAVICLE, tre	eatment of fracture of, not being a service to which item 47465 applies (Anaes.)
47462	Fee: \$112.85	<b>Benefit:</b> 75% = \$84.65 85% = \$95.95
	CLAVICLE, tre	eatment of fracture of, by open reduction (Anaes.) (Assist.)
47465	Fee: \$226.00	<b>Benefit:</b> 75% = \$169.50 85% = \$192.10
	STERNUM, tre	eatment of fracture of, not being a service to which item 47467 applies (Anaes.)
47466	Fee: \$112.85	<b>Benefit:</b> 75% = \$84.65 85% = \$95.95
	STERNUM, treatment of fracture of, by open reduction (Anaes.)	
47467	Fee: \$226.00	<b>Benefit:</b> 75% = \$169.50
	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	
47468	Fee: \$432.95	<b>Benefit:</b> 75% = \$324.75 85% = \$368.05
		e), treatment of fracture of - each attendance
47471	Fee: \$43.00	<b>Benefit:</b> 75% = \$32.25 85% = \$36.55
		, treatment of fracture of, not involving disruption of pelvic ring or acetabulum
47474		
47474	Fee: \$188.20	<b>Benefit:</b> 75% = \$141.15 85% = \$160.00

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	PELVIC RING, treatment of fracture of, with disruption of pelvic rin	ng or acetabulum
47477	<b>Fee:</b> \$235.50 <b>Benefit:</b> 75% = \$176.65 85% = \$200.20	
	PELVIC RING, treatment of fracture of, requiring traction (Anaes.)	(Assist.)
47480	<b>Fee:</b> \$470.70 <b>Benefit:</b> 75% = \$353.05	
	PELVIC RING, treatment of fracture of, requiring control by externa	al fixation (Anaes.) (Assist.)
47483	<b>Fee:</b> \$564.85 <b>Benefit:</b> 75% = \$423.65	
	PELVIC RING, treatment of fracture of, by open reduction and invo segment, including diastasis of pubic symphysis (Anaes.) (Assist.)	lving internal fixation of anterior
47486	<b>Fee:</b> \$941.45 <b>Benefit:</b> 75% = \$706.10	
	PELVIC RING, treatment of fracture of, by open reduction and invo segment (including sacro-iliac joint), with or without fixation of ante	
47489	<b>Fee:</b> \$1,412.20 <b>Benefit:</b> 75% = \$1059.15	
	ACETABULUM, treatment of fracture of, and associated dislocation	n of hip (Anaes.)
47492	<b>Fee:</b> \$235.50 <b>Benefit:</b> 75% = \$176.65 85% = \$200.20	
	ACETABULUM, treatment of fracture of, and associated dislocation (Assist.)	n of hip, requiring traction (Anaes.)
47495	<b>Fee:</b> \$470.70 <b>Benefit:</b> 75% = \$353.05 85% = \$400.10	
	ACETABULUM, treatment of fracture of, and associated dislocation with or without traction (Anaes.) (Assist.)	n of hip, requiring internal fixation,
47498	Fee: \$706.05 Benefit: 75% = \$529.55	
	ACETABULUM, treatment of single column fracture of, by open re- including any osteotomy, osteectomy or capsulotomy required for ex excluding services to which item 47933 or 47936 apply (Anaes.) (As	posure and subsequent repair, and
47501	<b>Fee:</b> \$941.45 <b>Benefit:</b> 75% = \$706.10	
	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.)	
47504	<b>Fee:</b> \$1,412.20 <b>Benefit:</b> 75% = \$1059.15 85% = \$1330.50	
	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.)	
47507	<b>Fee:</b> \$1,412.20 <b>Benefit:</b> 75% = \$1059.15	
	ACETABULUM, treatment of double column fracture of, by open reincluding any osteotomy, osteectomy or capsulotomy required for execuding services to which item 47933 or 47936 apply (Anaes.) (As	posure and subsequent repair, and
47510	<b>Fee:</b> \$1,412.20 <b>Benefit:</b> 75% = \$1059.15	
	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring interr associated with a service to which items 47501 to 47510 apply (Anat	
47513		

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC	
	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45	
	FEMUR, treatme	ent of fracture of, by closed reduction or traction (Anaes.) (Assist.)	
47516	Fee: \$432.95	<b>Benefit:</b> 75% = \$324.75 85% = \$368.05	
	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.)		
47519	<b>Fee:</b> \$866.20 <b>Benefit:</b> 75% = \$649.65		
	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.)		
47522	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
47522	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.)		
17525			
47525	Fee: \$866.20Benefit: 75% = \$649.65FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)		
47528	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
	FEMUR, treatme	ent of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.)	
47531	Fee: \$960.25	<b>Benefit:</b> 75% = \$720.20	
		ar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring with or without internal fixation of 1 or more osteochondral fragments (Anaes.)	
47534	Fee: \$1,082.70	<b>Benefit:</b> 75% = \$812.05	
	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 appli (Anaes.) (Assist.)		
47537	Fee: \$432.95	<b>Benefit:</b> 75% = \$324.75 85% = \$368.05	
	HIP SPICA OR	SHOULDER SPICA, application of, as an independent procedure (Anaes.)	
47540	Fee: \$216.50	<b>Benefit:</b> 75% = \$162.40 85% = \$184.05	
	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.)		
47543	Fee: \$226.00	<b>Benefit:</b> 75% = \$169.50 85% = \$192.10	
	TIBIA, plateau o	of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)	
47546	Fee: \$338.85	<b>Benefit:</b> 75% = \$254.15 85% = \$288.05	
		of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.)	
47549	<b>Fee:</b> \$451.95	<b>Benefit:</b> 75% = \$339.00	
7 <i>137)</i>	TIBIA, plateau o	of, treatment of both medial and lateral fractures of, not being a service to which item applies (Anaes.) (Assist.)	
47552	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45 85% = \$320.10	
		of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)	
47555	<b>Fee:</b> \$564.85	<b>Benefit:</b> 75% = \$423.65	
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T8. SUF	GICAL OPERATI	ONS 15. ORTHOPAEDIC	
	TIBIA, plateau of	, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.)	
47558	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
		eatment of fracture of, by cast immobilisation, not being a service to which item 570 or 47573 applies (Anaes.)	
47561	Fee: \$272.95	<b>Benefit:</b> 75% = \$204.75 85% = \$232.05	
	TIBIA, shaft of, t fracture (Anaes.)	reatment of fracture of, by closed reduction, with or without treatment of fibular	
47564	Fee: \$409.55	<b>Benefit:</b> 75% = \$307.20 85% = \$348.15	
	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)		
47565	Fee: \$712.40	<b>Benefit:</b> 75% = \$534.30	
	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.)		
47566	Fee: \$908.05	<b>Benefit:</b> 75% = \$681.05	
	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)		
47567	Fee: \$475.35	<b>Benefit:</b> 75% = \$356.55 85% = \$404.05	
	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)		
47570	Fee: \$546.00	<b>Benefit:</b> 75% = \$409.50 85% = \$464.30	
	TIBIA, shaft of, t fibula fracture (A	reatment of intra-articular fracture of, by open reduction, with or without treatment of naes.) (Assist.)	
47573	Fee: \$682.55	<b>Benefit:</b> 75% = \$511.95	
	FIBULA, treatme	nt of fracture of (Anaes.)	
47576	Fee: \$112.85	<b>Benefit:</b> 75% = \$84.65 85% = \$95.95	
	PATELLA, treat	nent of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)	
47579	Fee: \$160.05	<b>Benefit:</b> 75% = \$120.05 85% = \$136.05	
	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes. (Assist.)		
47582	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20	
	PATELLA, treat	nent of fracture of, by internal fixation (Anaes.) (Assist.)	
47585	Fee: \$423.75	<b>Benefit:</b> 75% = \$317.85	
	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.)		
47588	Fee: \$1,317.80	<b>Benefit:</b> 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.)		

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Fee: \$409.55       Benefit: 75% = \$307.20       85% = \$348.15         TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.)	
ction, with or without	

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	METATARSAL, 1 of, treatment of fracture of (Ana	es.)
47633	<b>Fee:</b> \$112.85 <b>Benefit:</b> 75% = \$84.65 85% =	\$95.95
	METATARSAL, 1 of, treatment of fracture of, by c	losed reduction (Anaes.)
47636	<b>Fee:</b> \$169.50 <b>Benefit:</b> 75% = \$127.15 85% =	= \$144.10
	METATARSAL, 1 of, treatment of fracture of, by o	pen reduction (Anaes.)
47639	<b>Fee:</b> \$226.00 <b>Benefit:</b> 75% = \$169.50 85% =	= \$192.10
	METATARSALS, 2 of, treatment of fracture of (Ar	aes.)
47642	<b>Fee:</b> \$150.75 <b>Benefit:</b> 75% = \$113.10 85% =	= \$128.15
	METATARSALS, 2 of, treatment of fracture of, by	closed reduction (Anaes.)
47645	<b>Fee:</b> \$226.00 <b>Benefit:</b> 75% = \$169.50 85% =	= \$192.10
	METATARSALS, 2 of, treatment of fracture of, by	open reduction (Anaes.) (Assist.)
47648	<b>Fee:</b> \$301.05 <b>Benefit:</b> 75% = \$225.80	
	METATARSALS, 3 or more of, treatment of fracture	re of (Anaes.)
47651	<b>Fee:</b> \$235.50 <b>Benefit:</b> 75% = \$176.65 85% =	= \$200.20
	METATARSALS, 3 or more of, treatment of fracture	re of, by closed reduction (Anaes.) (Assist.)
47654	<b>Fee:</b> \$353.05 <b>Benefit:</b> 75% = \$264.80 85% =	= \$300.10
	METATARSALS, 3 or more of, treatment of fracture	re of, by open reduction (Anaes.) (Assist.)
47657	<b>Fee:</b> \$470.70 <b>Benefit:</b> 75% = \$353.05	
	PHALANX OF GREAT TOE, treatment of fracture	of, by closed reduction (Anaes.)
47663	<b>Fee:</b> \$141.25 <b>Benefit:</b> 75% = \$105.95 85% =	= \$120.10
	PHALANX OF GREAT TOE, treatment of fracture	of, by open reduction (Anaes.)
47666	<b>Fee:</b> \$235.50 <b>Benefit:</b> 75% = \$176.65 85% =	= \$200.20
	PHALANX OF TOE (other than great toe), 1 of, tre	atment of fracture of, by open reduction (Anaes.)
47672	<b>Fee:</b> \$112.85 <b>Benefit:</b> 75% = \$84.65 85% =	\$95.95
	PHALANX OF TOE (other than great toe), more th (Anaes.)	an 1 of, treatment of fracture of, by open reduction
47678	<b>Fee:</b> \$169.50 <b>Benefit:</b> 75% = \$127.15 85% =	= \$144.10
	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance	
47681	<b>Fee:</b> \$43.00 <b>Benefit:</b> 75% = \$32.25 85% =	\$36.55
	SPINE, treatment of fracture, dislocation or fracture immobilisation by calipers or halo (Anaes.) (Assist.)	
47684	<b>Fee:</b> \$753.25 <b>Benefit:</b> 75% = \$564.95 85% =	= \$671.55
47687	SPINE, treatment of fracture, dislocation or fracture	-dislocation, with spinal cord involvement, with

T8. SUR	GICAL OPERATI	ONS	15. ORTHOPAEDIC
	immobilisation by	y calipers or halo, and including up to 14 days	post-operative care (Assist.)
	Fee: \$1,317.80	<b>Benefit:</b> 75% = \$988.35	
	-	of fracture, dislocation or fracture-dislocation y calipers or halo, requiring reduction by close	
47690	Fee: \$1,035.55	<b>Benefit:</b> 75% = \$776.70	
		of fracture, dislocation or fracture-dislocation y calipers or halo, requiring reduction by close re (Assist.)	
47693	Fee: \$1,317.80	<b>Benefit:</b> 75% = \$988.35	
		of fracture or dislocation of, without cord investal (Anaes.) (Assist.)	olvement, undertaken in the operating
47696	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45	
	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.)		
47699	Fee: \$1,506.45	<b>Benefit:</b> 75% = \$1129.85	
		of fracture, dislocation or fracture-dislocation without internal fixation, including up to 14 d	
47702	Fee: \$1,882.95	<b>Benefit:</b> 75% = \$1412.25	
	SKULL, treatment of fracture of, each attendance		
47703	Fee: \$43.00	<b>Benefit:</b> 75% = \$32.25 85% = \$36.55	
	SKULL CALIPE	RS, insertion of, as an independent procedure	(Anaes.) (Assist.)
47705	Fee: \$282.35	<b>Benefit:</b> 75% = \$211.80	
	PLASTER JACK	ET, application of, as an independent procedu	re (Anaes.)
47708	Fee: \$216.50	<b>Benefit:</b> 75% = \$162.40 85% = \$184.05	
	HALO, applicatio	on of, as an independent procedure (Anaes.) (A	Assist.)
47711	Fee: \$320.15	<b>Benefit:</b> 75% = \$240.15	
		on of, in addition to spinal fusion for scoliosis,	or other conditions (Anaes.)
47714	Fee: \$240.05	<b>Benefit:</b> 75% = \$180.05	
.,,,,,		CIC TRACTION - application of both halo and	l thoracic jacket (Anaes.) (Assist.)
47717	Fee: \$423.75	<b>Benefit:</b> 75% = \$317.85	
.,,1		AL TRACTION, as an independent procedure	(Anaes.) (Assist.)
47720	Fee: \$423.75	<b>Benefit:</b> 75% = \$317.85 85% = \$360.20	
		AL TRACTION, in conjunction with a major split $r_{1}$	pine operation (Anaes.) (Assist.)
47723	Fee: \$423.75	<b>Benefit:</b> 75% = \$317.85 85% = \$360.20	· / ` /
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T8. SUR		IONS 15. ORTHOPAEDIC	
	small quantity (A	naes.)	
	Fee: \$141.25	<b>Benefit:</b> 75% = \$105.95	
	BONE GRAFT, large quantity (A	harvesting of, via separate incision, in conjunction with another service - autogenous - naes.)	
47729	Fee: \$235.50	<b>Benefit:</b> 75% = \$176.65	
	VASCULARISE (Anaes.) (Assist.)	D PEDICLE BONE GRAFT, harvesting of, in conjunction with another service	
47732	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45	
	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance		
47735	Fee: \$43.05	<b>Benefit:</b> 75% = \$32.30 85% = \$36.60	
	NASAL BONES	, treatment of fracture of, by reduction (Anaes.)	
47738	Fee: \$235.50	<b>Benefit:</b> 75% = \$176.65 85% = \$200.20	
	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.)		
47741	Fee: \$480.35	<b>Benefit:</b> 75% = \$360.30	
	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)		
47753	Fee: \$406.65	<b>Benefit:</b> 75% = \$305.00	
		atment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or (Anaes.) (Assist.)	
47756	Fee: \$406.65	<b>Benefit:</b> 75% = \$305.00	
	ZYGOMATIC B other approach (2	ONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or Anaes.)	
47762	Fee: \$238.80	<b>Benefit:</b> 75% = \$179.10 85% = \$203.00	
		ONE, treatment of fracture of, requiring surgical reduction and involving internal or at 1 site (Anaes.) (Assist.)	
47765	Fee: \$392.10	<b>Benefit:</b> 75% = \$294.10	
	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)		
47768	Fee: \$480.35	<b>Benefit:</b> 75% = \$360.30	
	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.)		
47771	Fee: \$551.85	<b>Benefit:</b> 75% = \$413.90	
	MAXILLA, treat	ment of fracture of, requiring open operation (Anaes.) (Assist.)	
47774	Fee: \$435.65	<b>Benefit:</b> 75% = \$326.75	
	MANDIBLE, tre	atment of fracture of, requiring open reduction (Anaes.) (Assist.)	
47777	Fee: \$435.65	<b>Benefit:</b> 75% = \$326.75	

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC	
	MAXILLA, treats (Anaes.) (Assist.)	ment of fracture of, requiring open reduction and internal fixation not involving plate(s)	
47780	Fee: \$566.35	<b>Benefit:</b> 75% = \$424.80	
	MANDIBLE, trea plate(s) (Anaes.)	atment of fracture of, requiring open reduction and internal fixation not involving (Assist.)	
47783	Fee: \$566.35	<b>Benefit:</b> 75% = \$424.80 85% = \$484.65	
	MAXILLA, treat (Anaes.) (Assist.)	ment of fracture of, requiring open reduction and internal fixation involving plate(s)	
47786	Fee: \$718.75	<b>Benefit:</b> 75% = \$539.10	
	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.)		
47789	Fee: \$718.75	<b>Benefit:</b> 75% = \$539.10	
		GENERAL	
	BONE CYST, inj	jection into or aspiration of (Anaes.)	
47900	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85% = \$144.10	
	EPICONDYLITI	S, open operation for (Anaes.)	
47903	<b>Fee:</b> \$235.50	<b>Benefit:</b> 75% = \$176.65 85% = \$200.20	
		OF TOE, removal of, not being a service to which item 47906 applies (Anaes.)	
47904	<b>Fee:</b> \$56.50 <b>Benefit:</b> 75% = \$42.40 85% = \$48.05		
		OF TOE, removal of, in the operating theatre of a hospital (Anaes.)	
47906			
47900			
	(See para TN.8.4 of	f explanatory notes to this Category)	
47912	Fee: \$56.50	<b>Benefit:</b> 75% = \$42.40 85% = \$48.05	
	INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)		
47915	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85% = \$144.10	
	INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)		
47916	Fee: \$85.15	<b>Benefit:</b> 75% = \$63.90 85% = \$72.40	
	INGROWING TO	OENAIL, radical excision of nailbed (Anaes.)	
47918	Fee: \$235.50	<b>Benefit:</b> 75% = \$176.65 85% = \$200.20	
		H STIMULATOR, insertion of (Anaes.) (Assist.)	
47920	Fee: \$380.80	<b>Benefit:</b> 75% = \$285.60	
77720		P PIN OR WIRE, insertion of, as an independent procedure (Anaes.)	
47921			

T8. SUF	GICAL OPERATIONS		15. ORTHOPAEDIC
	<b>Fee:</b> \$112.85 <b>Benefit:</b> 7	75% = \$84.65 85% = \$95.95	
		EW, 1 or more of, which were inser nd suture, not being a service to whi	ted for internal fixation purposes, ich item 47927 or 47930 applies - per
47924	<b>Fee:</b> \$37.65 <b>Benefit:</b> 7	75% = \$28.25 85% = \$32.05	
		EW, 1 or more of, which were inser eatre of a hospital - per bone (Anaes	
47927	<b>Fee:</b> \$141.25 <b>Benefit:</b> 7	75% = \$105.95	
	were inserted for internal fixation		SCREWS, 1 or more of, all of which a service associated with a service to
47930	<b>Fee:</b> \$263.60 <b>Benefit:</b> 7	75% = \$197.70	
		NORE THAN 20MM OF GROWTH any associated bursa, not being a ser	· · · · · · · · · · · · · · · · · · ·
47933	(See para TN.8.112 of explanatory <b>Fee:</b> \$207.00 <b>Benefit:</b> 7	75% = \$155.25 85% = \$175.95	
	LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Anaes.) (Assist.)		
47936	(See para TN.8.112 of explanatory <b>Fee:</b> \$254.20 <b>Benefit:</b> 7	v notes to this Category) 75% = \$190.65	
	EXTERNAL FIXATION, remo	oval of, in the operating theatre of a	hospital (Anaes.)
47948	<b>Fee:</b> \$160.05 <b>Benefit:</b> 7	75% = \$120.05	
	EXTERNAL FIXATION, remo grafting or both (Anaes.)	oval of, in conjunction with operation	ons involving internal fixation or bone
47951	<b>Fee:</b> \$188.20 <b>Benefit:</b> 7	75% = \$141.15 85% = \$160.00	
	TENDON, repair of, as an inde	ependent procedure (Anaes.) (Assist	.)
47954	<b>Fee:</b> \$376.55 <b>Benefit:</b> 7	75% = \$282.45 85% = \$320.10	
		of, as an independent procedure (Ana	aes.) (Assist.)
47957	<b>Fee:</b> \$282.35 <b>Benefit:</b> 7	75% = \$211.80	
	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.)		nother item in this Group applies
47960	<b>Fee:</b> \$131.85 <b>Benefit:</b> 7	75% = \$98.90 85% = \$112.10	
	TENOTOMY, OPEN, with or v Group applies (Anaes.)	without tenoplasty, not being a servi	ice to which another item in this
47963	<b>Fee:</b> \$216.50 <b>Benefit:</b> 7	75% = \$162.40 85% = \$184.05	
		RANSFER, as an independent proce	edure (Anaes.) (Assist.)
47966	<b>Fee:</b> \$432.95 <b>Benefit:</b> 7	75% = \$324.75	

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	(Assist.)	
	Fee: \$263.60	<b>Benefit:</b> 75% = \$197.70
	TENDON SHEA Group applies (A	ATH, open operation for teno-vaginitis, not being a service to which another item in this Anaes.)
47972	Fee: \$210.60	<b>Benefit:</b> 75% = \$157.95
		CALF, decompression fasciotomy of, for acute compartment syndrome, requiring cle and deep tissue (Anaes.) (Assist.)
47975	Fee: \$369.15	<b>Benefit:</b> 75% = \$276.90
		CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring cle and deep tissue (Anaes.)
47978	Fee: \$224.20	<b>Benefit:</b> 75% = \$168.15
		LF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, ice to which another item applies (Anaes.)
47981	Fee: \$150.55	<b>Benefit:</b> 75% = \$112.95 85% = \$128.00
	FORAGE (Drill	decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.)
47982	Fee: \$364.90	<b>Benefit:</b> 75% = \$273.70
		BONE GRAFTS
	FEMUR, bone g	graft to (Anaes.) (Assist.)
48200	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95
	FEMUR, bone g	graft to, with internal fixation (Anaes.) (Assist.)
48203	Fee: \$913.25	<b>Benefit:</b> 75% = \$684.95
	TIBIA, bone gra	ft to (Anaes.) (Assist.)
48206	Fee: \$565.45	<b>Benefit:</b> 75% = \$424.10
		ft to, with internal fixation (Anaes.) (Assist.)
48209	<b>Fee:</b> \$724.95	<b>Benefit:</b> 75% = \$543.75
40207		ne graft to (Anaes.) (Assist.)
49212	<b>Fee:</b> \$565.45	<b>Benefit:</b> 75% = \$424.10
48212		ne graft to, with internal fixation (Anaes.) (Assist.)
40215		
48215	Fee: \$724.95	Benefit: 75% = \$543.75
	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.)	
48218	<b>Fee:</b> \$565.45	<b>Benefit:</b> 75% = \$424.10
	KADIUS AND	ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)
48221	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95
	RADIUS OR U	LNA, bone graft to (Anaes.) (Assist.)
48224	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45

T8. SUF	RGICAL OPERATI	ONS	15. ORTHOPAEDIC
	RADIUS OR UL	NA, bone graft to, with internal fixa	tion of 1 or both bones (Anaes.) (Assist.)
48227	Fee: \$489.55	<b>Benefit:</b> 75% = \$367.20	
	SCAPHOID, bon	e graft to, for non-union (Anaes.) (A	Assist.)
48230	Fee: \$423.75	<b>Benefit:</b> 75% = \$317.85	
	SCAPHOID, bon	e graft to, for non-union, with interr	al fixation (Anaes.) (Assist.)
48233	Fee: \$611.90	<b>Benefit:</b> 75% = \$458.95	
	SCAPHOID, bon (Assist.)	e graft to, for mal-union, including o	osteotomy, bone graft and internal fixation (Anaes.)
48236	Fee: \$800.20	<b>Benefit:</b> 75% = \$600.15	
	BONE GRAFT, 1	not being a service to which another	item in this Group applies (Anaes.) (Assist.)
48239	Fee: \$442.45	<b>Benefit:</b> 75% = \$331.85	
	BONE GRAFT, v (Anaes.) (Assist.)		rvice to which another item in this Group applies
48242	Fee: \$611.90	<b>Benefit:</b> 75% = \$458.95	
		OSTEOTOMY ANI	OSTEECTOMY
		vices to which item 49848 or 49851	OR SESAMOID BONE, osteotomy or osteectomy applies, any of items 49848, 49851, 47933 or
48400	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20	
		METATARSAL, osteotomy or osteo items 47933 or 47936 apply (Anaes	ctomy of, with internal fixation, and excluding c.) (Assist.)
48403	Fee: \$517.80	<b>Benefit:</b> 75% = \$388.35	
		omy or osteectomy of, excluding ser	(other than acromion), RIB, TARSUS OR vices to which items 47933 or 47936 apply
48406	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20	
	CARPUS, osteoto		(other than Acromion), RIB, TARSUS OR fixation, and excluding services to which items
48409	Fee: \$517.80	<b>Benefit:</b> 75% = \$388.35	
	HUMERUS, oste (Anaes.) (Assist.)		services to which items 47933 or 47936 apply
48412	Fee: \$630.65	<b>Benefit:</b> 75% = \$473.00	
		otomy or osteectomy of, with intern pply (Anaes.) (Assist.)	al fixation, and excluding services to which items
48415	Fee: \$800.20	<b>Benefit:</b> 75% = \$600.15	
10.115	TIBIA, osteotom (Assist.)	y or osteectomy of, excluding servic	es to which items 47933 or 47936 apply (Anaes.)
48418			

T8. SUF		ONS	15. ORTHOPAEDIC	
	Fee: \$630.65	<b>Benefit:</b> 75% = \$473.00		
	TIBIA, osteotom or 47936 apply (.		and excluding services to which items 47933	
48421	Fee: \$800.20	<b>Benefit:</b> 75% = \$600.15		
		osteotomy or osteectomy of, other than a set impingement, or to which item 47933 or 4		
48424	(See para TN.8.127 <b>Fee:</b> \$753.25	7 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$564.95		
		LVIS, osteotomy or osteectomy of, with int 33 or 47936 apply (Anaes.) (Assist.)	ernal fixation, and excluding services to	
48427	Fee: \$913.25	<b>Benefit:</b> 75% = \$684.95		
		EPIPHYSEODES	SIS	
	FEMUR, epiphys	siodesis of (Anaes.) (Assist.)		
48500	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20		
	TIBIA AND FIB	ULA, epiphysiodesis of (Anaes.) (Assist.)		
48503	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20		
	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)			
48506	<b>Fee:</b> \$489.55	<b>Benefit:</b> 75% = \$367.20		
	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.)			
48509	Fee: \$235.50	<b>Benefit:</b> 75% = \$176.65		
		SIS, operation to prevent closure of plate (A	Anaes.) (Assist.)	
48512	<b>Fee:</b> \$894.40	<b>Benefit:</b> 75% = \$670.80		
		SPINE		
	SPINE, MANIPU	JLATION OF, performed in the operating	theatre of a hospital (Anaes.)	
48600	<b>Fee:</b> \$94.00	<b>Benefit:</b> 75% = \$70.50		
	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 whi item 48600 or 50115 applies (Anaes.)		etic are performed by the same medical	
48603	Fee: \$141.25	<b>Benefit:</b> 75% = \$105.95		
SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes		rumentation) (Anaes.) (Assist.)		
48606	Fee: \$1,317.80	<b>Benefit:</b> 75% = \$988.35		
	SCOLIOSIS, spi (Anaes.) (Assist.)	nal fusion for, using segmental instrumenta )	ation (C D, Zielke, Luque, or similar)	
48612	Fee: \$2,447.85	<b>Benefit:</b> 75% = \$1835.90		
48613		KYPHOSIS, spinal fusion for, using segme anterior and posterior approaches (Anaes.)		

T8. SUF		NS 15. ORTHOPAEDIC		
	Fee: \$3,481.80	<b>Benefit:</b> 75% = \$2611.35		
	SCOLIOSIS, re-ex grafting procedure	ploration for, involving adjustment or removal of instrumentation or simple bone (Anaes.) (Assist.)		
48615	Fee: \$442.45	<b>Benefit:</b> 75% = \$331.85		
	SCOLIOSIS, revis instrumentation (A	ion of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or naes.) (Assist.)		
48618	Fee: \$2,447.85	<b>Benefit:</b> 75% = \$1835.90		
	SCOLIOSIS, anter more than 4 levels	ior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not (Anaes.) (Assist.)		
48621	Fee: \$1,600.65	<b>Benefit:</b> 75% = \$1200.50		
	SCOLIOSIS, anter more than 4 levels	ior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - (Anaes.) (Assist.)		
48624	Fee: \$1,977.20	<b>Benefit:</b> 75% = \$1482.90		
		l fusion for, combined with segmental instrumentation (C D, Zielke or similar) down elvis (Anaes.) (Assist.)		
48627	Fee: \$2,541.85	<b>Benefit:</b> 75% = \$1906.40		
	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae includ graft and instrumentation in the presence of spinal cord involvement (Anaes.) (Assist.)			
48630	Fee: \$2,824.35	<b>Benefit:</b> 75% = \$2118.30		
	SCOLIOSIS, cong	enital, vertebral resection and fusion for (Anaes.) (Assist.)		
48632	Fee: \$1,561.30	<b>Benefit:</b> 75% = \$1171.00		
	PERCUTANEOUS LUMBAR PARTIAL OR TOTAL DISCECTOMY, 1 or more levels, not being a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.)			
48636	(See para TN.8.113 o <b>Fee:</b> \$809.55	of explanatory notes to this Category) Benefit: 75% = \$607.20 85% = \$727.85		
	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixa (Anaes.) (Assist.)			
48639	Fee: \$1,365.00	<b>Benefit:</b> 75% = \$1023.75		
		DY, disease of, excision and spinal fusion for, using segmental instrumentation, sing separate anterior and posterior approaches (Anaes.) (Assist.)		
48640	Fee: \$3,481.80	<b>Benefit:</b> 75% = \$2611.35		
	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 level (Anaes.) (Assist.)			
48642	Fee: \$800.20	<b>Benefit:</b> 75% = \$600.15		
	SPINE, posterior, l levels (Anaes.) (As	pone graft to, not being a service to which item 48648 or 48651 applies - more than 2 sist.)		
48645	Fee: \$1,082.70	<b>Benefit:</b> 75% = \$812.05		
48648		to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.)		

T8. SUF	GICAL OPERATIONS		15. ORTHOPAEDIC
	Fee: \$1,082.70 Be	enefit: 75% = \$812.05	
	SPINE, bone graft to, (j	postero-lateral fusion) - more than 2 levels (Anaes	s.) (Assist.)
48651	Fee: \$1,506.45 Be	enefit: 75% = \$1129.85	
	SPINAL FUSION (pos	terior interbody), with partial or total laminectom	y, 1 level (Anaes.) (Assist.)
48654	Fee: \$1,082.70 Be	enefit: 75% = \$812.05	
		terior interbody), with partial or total laminectom	y, more than 1 level (Anaes.)
48657	Fee: \$1,506.45 Be	enefit: 75% = \$1129.85	
	SPINAL FUSION (ante	erior interbody) to cervical, thoracic or lumbar reg	gions - 1 level (Anaes.) (Assist.)
48660		4 of explanatory notes to this Category) enefit: 75% = \$812.05	
	SPINAL FUSION (ante surgeon (Anaes.)	erior interbody) to cervical, thoracic or lumbar reg	zions - 1 level - principal
48663	· •	4 of explanatory notes to this Category) enefit: 75% = \$607.20	
	SPINAL FUSION (ante surgeon	erior interbody) to cervical, thoracic or lumbar reg	zions - 1 level - assisting
48666		4 of explanatory notes to this Category) enefit: 75% = \$367.20	
	SPINAL FUSION (ante (Anaes.) (Assist.)	erior interbody) to cervical, thoracic or lumbar reg	zions - more than 1 level
48669		4 of explanatory notes to this Category) enefit: 75% = \$1094.40	
	SPINAL FUSION (ante principal surgeon (Anae	erior interbody) to cervical, thoracic or lumbar reges.)	zions - more than 1 level -
48672		4 of explanatory notes to this Category) enefit: 75% = \$819.20	
	SPINAL FUSION (ante assisting surgeon	erior interbody) to cervical, thoracic or lumbar reg	zions - more than 1 level -
48675		4 of explanatory notes to this Category) enefit: 75% = \$494.40	
_	SPINE, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being service associated with a service to which items 48642 to 48675 apply (Anaes.) (Assist.)		
48678		enefit: 75% = \$424.10	
		internal fixation of (Harrington or similar), other a service to which any one of items 48642 to 486	
48681		Planatory notes to this Category) Planefit: 75% = \$706.10	
48684	SPINE, segmental inter	nal fixation of, other than for scoliosis, being a se	rvice associated with a service

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	to which any one of items 48642 to 48675 applies - 1 or 2 levels (Anaes.	) (Assist.)
	(See para TN.8.2, TN.8.115 of explanatory notes to this Category) Fee: \$941.45 Benefit: 75% = \$706.10	
	SPINE, segmental internal fixation of, other than for scoliosis, being a set to which items 48642 to 48675 apply - 3 or 4 levels (Anaes.) (Assist.)	ervice associated with a service
48687	(See para TN.8.115 of explanatory notes to this Category) <b>Fee:</b> \$1,317.80 <b>Benefit:</b> 75% = \$988.35	
	SPINE, segmental internal fixation of, other than for scoliosis, being a set to which items 48642 to 48675 apply - more than 4 levels (Anaes.) (Assi	
48690	(See para TN.8.115 of explanatory notes to this Category) <b>Fee:</b> \$1,506.45 <b>Benefit:</b> 75% = \$1129.85	
	Lumbar artificial intervertebral total disc replacement, at one level only, patient who:	including removal of disc, for a
	(a) has not had prior spinal fusion surgery at the same lumbar level; and	
	(b) does not have vertebral osteoporosis; and	
	(c) has failed conservative therapy;	
	other than a service associated with item 40300 or 40301 (Anaes.) (Assist	st.)
48691	(See para TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$1,793.65 <b>Benefit:</b> 75% = \$1345.25	
	Lumbar artificial intervertebral total disc replacement, at one level only, patient who:	including removal of disc, for a
	(a) has not had prior spinal fusion surgery at the same lumbar level; and	
	(b) does not have vertebral osteoporosis; and	
	(c) has failed conservative therapy;	
48692	other than a service associated with item 40300 or 40301-principal surge	eon (Anaes.) (Assist.)

T8. SUF	GICAL OPERATI	NS	15. ORTHOPAEDIC
	(See para TN.8.2 of <b>Fee:</b> \$1,208.95	explanatory notes to this Category) Benefit: 75% = \$906.75	
	Lumbar artificial patient who:	intervertebral total disc replacement, at one level only,	including removal of disc, for a
	(a) has not had pr	ior spinal fusion surgery at the same lumbar level; and	
	(b) does not have	vertebral osteoporosis; and	
	(c) has failed cons	servative therapy;	
	other than a servio	ce associated with item 40300 or 40301-assisting surge	eon (Anaes.) (Assist.)
48693	(See para TN.8.2 of <b>Fee:</b> \$584.70	explanatory notes to this Category) Benefit: 75% = \$438.55	
	Cervical artificial patient who:	intervertebral total disc replacement, at one level only	, including removal of disc, for a
	(a) has not had pr	ior spinal surgery at the same cervical level; and	
	(b) is skeletally m	ature; and	
	(c) has symptoma	tic degenerative disc disease with radiculopathy; and	
	(d) does not have vertebral osteoporosis; and		
	(e) has failed cons	servative therapy;	
	other than a service associated with item 40300 or 40301 (Anaes.) (Assist.)		st.)
48694	Fee: \$1,082.70	<b>Benefit:</b> 75% = \$812.05	
		SHOULDER	
	SHOULDER, exc (Anaes.) (Assist.)	ision of coraco-acromial ligament or removal of calciu	im deposit from cuff or both
48900	Fee: \$282.35	<b>Benefit:</b> 75% = \$211.80 85% = \$240.00	
		compression of subacromial space by acromioplasty, exal clavicle, or any combination (Anaes.) (Assist.)	xcision of coraco-acromial
48903	Fee: \$564.85	<b>Benefit:</b> 75% = \$423.65	
SHOULDER, repair of rotator cuff, including excision of coraco-acromial calcium deposit from cuff, or both - not being a service associated with a se applies (Anaes.) (Assist.)			
48906	Fee: \$564.85	<b>Benefit:</b> 75% = \$423.65	
	excision of coraco	air of rotator cuff, including decompression of subacro p-acromial ligament and distal clavicle, or any combina service to which item 48903 applies (Anaes.) (Assist.)	
48909	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
	SHOULDER, artl	nrotomy of (Anaes.) (Assist.)	
48912	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20 85% = \$280.20	

T8. SUF	GICAL OPERATIO	DNS 15. ORTHOPAEDIC	
	SHOULDER, her	i-arthroplasty of (Anaes.) (Assist.)	
48915	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
	SHOULDER, tota (Assist.)	replacement arthroplasty of, including any associated rotator cuff repair (Anaes.)	
48918	Fee: \$1,506.45	<b>Benefit:</b> 75% = \$1129.85	
	SHOULDER, tota	replacement arthroplasty, revision of (Anaes.) (Assist.)	
48921	Fee: \$1,553.40	<b>Benefit:</b> 75% = \$1165.05	
	SHOULDER, tota both (Anaes.) (Ass	replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or ist.)	
48924	Fee: \$1,788.85	<b>Benefit:</b> 75% = \$1341.65	
	SHOULDER pros	thesis, removal of (Anaes.) (Assist.)	
48927	Fee: \$367.05	<b>Benefit:</b> 75% = \$275.30	
	SHOULDER, stab	ilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.)	
48930	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.)		
48933	Fee: \$988.55	<b>Benefit:</b> 75% = \$741.45	
	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.)		
48936	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
SHOULDER, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)		rodesis of, with synovectomy if performed (Anaes.) (Assist.)	
48939	Fee: \$1,082.70	<b>Benefit:</b> 75% = \$812.05	
		rodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone fixation (Anaes.) (Assist.)	
48942	Fee: \$1,412.20	<b>Benefit:</b> 75% = \$1059.15	
		nostic arthroscopy of (including biopsy) - not being a service associated with any procedure of the shoulder region (Anaes.) (Assist.)	
48945	Fee: \$272.95	<b>Benefit:</b> 75% = \$204.75	
	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)		
48948	Fee: \$611.90	<b>Benefit:</b> 75% = \$458.95	
		roscopic division of coraco-acromial ligament including acromioplasty - not being a with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)	
48951	Fee: \$894.40	<b>Benefit:</b> 75% = \$670.80	
48954		roscopic total synovectomy of, including release of contracture when performed - not ociated with any other arthroscopic procedure of the shoulder region (Anaes.)	

T8. SUR	GICAL OPERATI	IONS 15. ORTHOPAEDIC
	(Assist.)	
	Fee: \$941.45	<b>Benefit:</b> 75% = \$706.10
	reattachment whe	hroscopic stabilisation of, for recurrent instability including labral repair or en performed - not being a service associated with any other arthroscopic procedure of on (Anaes.) (Assist.)
48957	Fee: \$1,082.70	<b>Benefit:</b> 75% = \$812.05
	assisted or mini c	construction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by h when performed - not being a service associated with any other procedure of the Anaes.) (Assist.)
48960	Fee: \$941.45	<b>Benefit:</b> 75% = \$706.10
		ELBOW
	ELBOW, arthroto (Anaes.) (Assist.)	omy of, involving 1 or more of lavage, removal of loose body or division of contracture
49100	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20
	ELBOW, ligamer	ntous stabilisation of (Anaes.) (Assist.)
49103	Fee: \$706.05	<b>Benefit:</b> 75% = \$529.55
	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)	
49106	<b>Fee:</b> \$941.45	<b>Benefit:</b> 75% = \$706.10 85% = \$859.75
	ELBOW, total sy	vnovectomy of (Anaes.) (Assist.)
49109	Fee: \$706.05	<b>Benefit:</b> 75% = \$529.55
19109		or other replacement of radial head (Anaes.) (Assist.)
40112	Fee: \$706.05	• · · · · · ·
49112		Benefit: 75% = \$529.55 int replacement of (Anaes.) (Assist.)
	ELBOW, total jo	int replacement of (Anaes.) (Assist.)
49115	Fee: \$1,129.65	<b>Benefit:</b> 75% = \$847.25
	ELBOW, total replacement arthroplasty of, revision procedure, including removal of pro (Assist.)	
49116	Fee: \$1,491.15	<b>Benefit:</b> 75% = \$1118.40
	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, i removal of prosthesis (Anaes.) (Assist.)	
49117	Fee: \$1,789.35	<b>Benefit:</b> 75% = \$1342.05
	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with a other arthroscopic procedure of the elbow (Anaes.) (Assist.)	
49118	Fee: \$272.95	<b>Benefit:</b> 75% = \$204.75
	release of contract	copic surgery involving any 1 or more of: drilling of defect, removal of loose body; cture or adhesions; chondroplasty; or osteoplasty - not being a service associated with copic procedure of the elbow (Anaes.) (Assist.)
49121	Fee: \$611.90	<b>Benefit:</b> 75% = \$458.95

49200	WRIST WRIST, arthrodesis of, with synovectomy if performed, with or of the radiocarpal joint (Anaes.) (Assist.)		
49200			
49200		without bone graft and internal fixation	
+7200	(See para TN.8.116 of explanatory notes to this Category) Fee: \$818.95 Benefit: 75% = \$614.25		
	WRIST, limited arthrodesis of the intercarpal joint, with synove bone graft (Anaes.) (Assist.)	ectomy if performed, with or without	
49203	(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$611.90 <b>Benefit:</b> 75% = \$458.95		
	WRIST, proximal carpectomy of, including styloidectomy when	n performed (Anaes.) (Assist.)	
49206	(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$564.85 <b>Benefit:</b> 75% = \$423.65		
	WRIST, total replacement arthroplasty of (Anaes.) (Assist.)		
49209	(See para TN.8.116 of explanatory notes to this Category) Fee: \$753.25 Benefit: 75% = \$564.95		
	WRIST, total replacement arthroplasty of, revision procedure, in (Assist.)	ncluding removal of prosthesis (Anaes.)	
49210	<b>Fee:</b> \$994.30 <b>Benefit:</b> 75% = \$745.75		
	WRIST, total replacement arthroplasty of, revision procedure, removal of prosthesis (Anaes.) (Assist.)	equiring bone grafting, including	
49211	<b>Fee:</b> \$1,193.15 <b>Benefit:</b> 75% = \$894.90		
	WRIST, arthrotomy of (Anaes.)		
49212	(See para TN.8.116 of explanatory notes to this Category) Fee: \$235.50 Benefit: 75% = \$176.65		
	WRIST, reconstruction of, including repair of single or multiple associated arthrotomy (Anaes.) (Assist.)	ligaments or capsules, including	
49215	(See para TN.8.116 of explanatory notes to this Category)           Fee: \$649.70         Benefit: 75% = \$487.30		
	WRIST, diagnostic arthroscopy of, including radiocarpal or mid - not being a service associated with any other arthroscopic proc (Assist.)		
49218	(See para TN.8.116 of explanatory notes to this Category) Fee: \$272.95 Benefit: 75% = \$204.75		
	WRIST, arthroscopic surgery of, involving any 1 or more of: dr release of adhesions; local synovectomy; or debridement of one with any other arthroscopic procedure of the wrist joint (Anaes.)	area - not being a service associated	
49221	(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$611.90 <b>Benefit:</b> 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.)		

T8. SUR	GICAL OPERATIO	NS	15. ORTHOPAEDIC	
	(See para TN.8.116 c <b>Fee:</b> \$706.05	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$529.55		
		pic pinning of osteochondral fragment or stabilisation ng a service associated with any other arthroscopic p		
49227	(See para TN.8.116 c <b>Fee:</b> \$706.05	of explanatory notes to this Category) Benefit: 75% = \$529.55		
		HIP		
	SACROILIAC JOI	INT arthrodesis of (Anaes.) (Assist.)		
49300	Fee: \$521.25	<b>Benefit:</b> 75% = \$390.95		
		, including lavage, drainage or biopsy when perform gery for femoroacetabular impingement (H) (Anaes.		
49303	(See para TN.8.127 c <b>Fee:</b> \$546.00	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$409.50		
	HIP arthrodesis of	, with synovectomy if performed (Anaes.) (Assist.)		
49306	Fee: \$1,082.70	<b>Benefit:</b> 75% = \$812.05		
HIP, arthrectomy or excision arthroplasty of, including removal of p (non cement )) (Anaes.) (Assist.)			thesis (Austin Moore or similar	
49309	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95		
	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.)			
49312	Fee: \$941.45	<b>Benefit:</b> 75% = \$706.10		
	HIP, arthroplasty o	f, unipolar or bipolar (Anaes.) (Assist.)		
49315	Fee: \$847.35	<b>Benefit:</b> 75% = \$635.55		
	HIP, total replacem	nent arthroplasty of, including minor bone grafting (A	Anaes.) (Assist.)	
49318	Fee: \$1,317.80	<b>Benefit:</b> 75% = \$988.35		
47510	. ,	nent arthroplasty of, including associated minor graft	ing, if performed - bilateral	
49319	Fee: \$2,315.30	<b>Benefit:</b> 75% = \$1736.50		
	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.)		ncluding obtaining of graft	
49321	Fee: \$1,600.65	<b>Benefit:</b> 75% = \$1200.50		
	HIP, total replacem (Assist.)	nent arthroplasty of, revision procedure including ren	noval of prosthesis (Anaes.)	
49324	Fee: \$1,882.95	<b>Benefit:</b> 75% = \$1412.25		
	HIP, total replacem	nent arthroplasty of, revision procedure requiring bor g of graft (Anaes.) (Assist.)	ne grafting to acetabulum,	
49327	Fee: \$2,165.35	<b>Benefit:</b> 75% = \$1624.05		

T8. SUF	GICAL OPERATI	ONS 15. ORTHOPAE	DIC	
		ment arthroplasty of, revision procedure requiring bone grafting to femur, including (Anaes.) (Assist.)	r >	
49330	Fee: \$2,165.35	<b>Benefit:</b> 75% = \$1624.05		
		ment arthroplasty of, revision procedure requiring bone grafting to both acetabulum ing obtaining of graft (Anaes.) (Assist.)	l	
49333	Fee: \$2,447.85	<b>Benefit:</b> 75% = \$1835.90		
	treatment of the f	a fracture of the femur where revision total hip replacement is required as part of th racture (not including intra-operative fracture), being a service associated with a ser 324 to 49333 apply (Anaes.) (Assist.)		
49336	Fee: \$357.70	<b>Benefit:</b> 75% = \$268.30		
	HIP, revision tota cm in length (Ana	l replacement of, requiring anatomic specific allograft of proximal femur greater that tes.) (Assist.)	an 5	
49339	Fee: \$2,777.30	<b>Benefit:</b> 75% = \$2083.00		
	HIP, revision tota	l replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assi	ist.)	
49342	Fee: \$2,777.30	<b>Benefit:</b> 75% = \$2083.00		
	HIP, revision tota (Anaes.) (Assist.)	l replacement of, requiring anatomic specific allograft of both femur and acetabulur	n	
49345	Fee: \$3,295.10	<b>Benefit:</b> 75% = \$2471.35		
		roplasty with replacement of acetabular liner or ceramic head, not requiring remova nt or acetabular shell (Anaes.) (Assist.)	ıl of	
49346	Fee: \$847.35	<b>Benefit:</b> 75% = \$635.55		
	HIP, diagnostic as the hip (Anaes.) (	throscopy of, not being a service associated with any other arthroscopic procedure (Assist.)	of	
49360	Fee: \$343.95	<b>Benefit:</b> 75% = \$258.00		
		throscopy of, with synovial biopsy, not being a service associated with any other edure of the hip (Anaes.) (Assist.)		
49363	Fee: \$414.20	<b>Benefit:</b> 75% = \$310.65 85% = \$352.10		
	Hip, arthroscopic surgery of, other than a service associated with another arthroscopic procedure of the hip, or a service associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.)			
49366	(See para TN.8.127 <b>Fee:</b> \$611.90	of explanatory notes to this Category) Benefit: 75% = \$458.95		
	KNEE			
		y of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose ody (Anaes.) (Assist.)	;	
49500	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45		
	chondroplasty of,	total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon which another item in this Group applies) - any 1 procedure (Anaes.) (Assist.)	(not	

T8. SUF	GICAL OPERAT	IONS	15. ORTHOPAEDIC
	chondroplasty of	total meniscectomy of, repair of collateral of , osteoplasty of, patellofemoral stabilisation o which another item in this Group applies) -	or single transfer of ligament or tendon (not
49506	Fee: \$734.40	<b>Benefit:</b> 75% = \$550.80	
	KNEE, total syne	ovectomy or arthrodesis with synovectomy is	f performed (Anaes.) (Assist.)
49509	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95	
	KNEE, arthrodes	sis of, with synovectomy if performed, with a	removal of prosthesis (Anaes.) (Assist.)
49512	Fee: \$1,082.70	<b>Benefit:</b> 75% = \$812.05	
		of prosthesis, cemented or uncemented, incluedure (Anaes.) (Assist.)	uding associated cement, as the first stage
49515	Fee: \$847.35	<b>Benefit:</b> 75% = \$635.55	
	KNEE, hemiarth	roplasty of (Anaes.) (Assist.)	
49517	Fee: \$1,206.35	<b>Benefit:</b> 75% = \$904.80	
	KNEE, total repl	acement arthroplasty of (Anaes.) (Assist.)	
49518	Fee: \$1,317.80	<b>Benefit:</b> 75% = \$988.35	
	KNEE, total repl (Anaes.) (Assist.	acement arthroplasty of, including associated	d minor grafting, if performed - bilateral
49519	Fee: \$2,315.30	<b>Benefit:</b> 75% = \$1736.50	
		acement arthroplasty of, requiring major bor t (Anaes.) (Assist.)	ne grafting to femur or tibia, including
49521	Fee: \$1,600.65	<b>Benefit:</b> 75% = \$1200.50	
		acement arthroplasty of, requiring major bor t (Anaes.) (Assist.)	ne grafting to femur and tibia, including
49524	Fee: \$1,882.95	<b>Benefit:</b> 75% = \$1412.25	
	KNEE, total repl (Assist.)	acement arthroplasty of, revision procedure,	including removal of prosthesis (Anaes.)
49527	Fee: \$1,600.65	<b>Benefit:</b> 75% = \$1200.50	
		acement arthroplasty of, revision procedure, ng of graft and including removal of prosthe	
49530	Fee: \$1,977.20	<b>Benefit:</b> 75% = \$1482.90	
		acement arthroplasty of, revision procedure, btaining of graft and including removal of pr	
49533	Fee: \$2,259.65	<b>Benefit:</b> 75% = \$1694.75	
	KNEE, patello-fe	emoral joint of, total replacement arthroplast	y as a primary procedure (Anaes.) (Assist.)
49534	Fee: \$449.55	<b>Benefit:</b> 75% = \$337.20	
49536		reconstruction of, for chronic instability (operal ligaments, including notchplasty when p	

T8. SUF	GICAL OPERAT	IONS	15. ORTHOPAEDIC	
	with any other a	throscopic procedure of the kne	e (Anaes.) (Assist.)	
	Fee: \$941.45	<b>Benefit:</b> 75% = \$706.10		
	including notchp	lasty when performed and surge em in this Group applies or a ser	ent or ligaments (open or arthroscopic, or both), ery to other internal derangements, not being a service to vice associated with any other arthroscopic procedure	
49539	Fee: \$941.45	<b>Benefit:</b> 75% = \$706.10		
	including notchp	lasty, meniscus repair, extracap	nt or ligaments (open or arthroscopic, or both), sular procedure and debridement when performed, not copic procedure of the knee (Anaes.) (Assist.)	
49542	Fee: \$1,317.80	<b>Benefit:</b> 75% = \$988.35		
	KNEE, revision	arthrodesis of, with synovectom	y if performed (Anaes.) (Assist.)	
49545	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95		
	KNEE, revision	of patello-femoral stabilisation (	Anaes.) (Assist.)	
49548	Fee: \$941.45	<b>Benefit:</b> 75% = \$706.10		
	KNEE, revision		i36, 49539 or 49542 applies (Anaes.) (Assist.)	
49551	Fee: \$1,317.80	<b>Benefit:</b> 75% = \$988.35		
			omic specific allograft of tibia or femur (Anaes.)	
49554	Fee: \$1,882.95	<b>Benefit:</b> 75% = \$1412.25		
	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.)			
49557	(See para TN.8.11) <b>Fee:</b> \$272.95	7 of explanatory notes to this Categ Benefit: 75% = \$204.75	ory)	
	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - no associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)			
49558	<b>Fee:</b> \$272.95	<b>Benefit:</b> 75% = \$204.75		
	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.)			
49559	Fee: \$408.70	<b>Benefit:</b> 75% = \$306.55		
		elease - not being a service assoc	nore of: partial or total meniscectomy, removal of loose ciated with any other arthroscopic procedure of the knee	
49560	Fee: \$551.60	<b>Benefit:</b> 75% = \$413.70		
49561	removal of loose	body or lateral release; where t	lving 1 or more of: partial or total meniscectomy, he procedure includes associated debridement, h any other arthroscopic procedure of the knee region	

T8. SUF	RGICAL OPERAT	ONS 15. ORTHOPAEDIC			
	(Anaes.) (Assist.)				
	Fee: \$674.00	<b>Benefit:</b> 75% = \$505.50			
	removal of loose drilling or carbor	OSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, body or lateral release; where the procedure includes chondroplasty requiring multiple fibre (or similar) implant and associated debridement or osteoplasty - not associated hroscopic procedure of the knee region (Anaes.) (Assist.)			
49562	Fee: \$735.50	<b>Benefit:</b> 75% = \$551.65			
	chondral graft (ex	bic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or cluding autologous chondrocyte implantation or matrix-induced autologous antation) -not associated with any other arthroscopic procedure of the knee region			
49563	(See para TN.8.117 <b>Fee:</b> \$796.70	of explanatory notes to this Category) Benefit: 75% = \$597.55			
	release, medial ca	moral stabilisation of, combined arthroscopic and open procedure, including lateral psulorrhaphy and tendon transfer, not being a service associated with any other edure of the knee (Anaes.) (Assist.)			
49564	Fee: \$919.05	<b>Benefit:</b> 75% = \$689.30			
		bic total synovectomy of, not being a service associated with any other arthroscopic stnee (Anaes.) (Assist.)			
49566	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95			
	KNEE, mobilisat (Anaes.) (Assist.)	on for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty)			
49569	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95			
		ANKLE			
	ANKLE, diagnos	tic arthroscopy of, including biopsy (Anaes.) (Assist.)			
49700	Fee: \$272.95	<b>Benefit:</b> 75% = \$204.75			
	ANKLE, arthroso of the ankle (Ana	opic surgery of, not being a service associated with any other arthroscopic procedure es.) (Assist.)			
49703	Fee: \$611.90	<b>Benefit:</b> 75% = \$458.95			
	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.)				
49706	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20			
	ANKLE, ligamer	tous stabilisation of (Anaes.) (Assist.)			
49709	Fee: \$706.05	<b>Benefit:</b> 75% = \$529.55			
		esis of, with synovectomy if performed (Anaes.) (Assist.)			
49712	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95			
47/12		nt replacement of (Anaes.) (Assist.)			
40 <b>-</b> 4-		• • • • • •			
49715	<b>Fee:</b> \$1,129.65	<b>Benefit:</b> 75% = \$847.25			
49716	ANKLE, total rej	lacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)			

T8. SUF		IONS	15. ORTHOPAEDIC	
	(Assist.)			
	Fee: \$1,491.15	<b>Benefit:</b> 75% = \$1118.40		
		placement arthroplasty of, revision procedure, requiring basis (Anaes.) (Assist.)	oone grafting, including	
49717	Fee: \$1,789.35	<b>Benefit:</b> 75% = \$1342.05		
	ANKLE, Achille	s' tendon or other major tendon, repair of (Anaes.) (Assis	t.)	
49718	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45		
	ANKLE, Achille	s' tendon rupture managed by non-operative treatment		
49721	Fee: \$235.50	<b>Benefit:</b> 75% = \$176.65 85% = \$200.20		
	ANKLE, Achille	s' tendon, secondary repair or reconstruction of (Anaes.)	(Assist.)	
49724	<b>Fee:</b> \$659.15	<b>Benefit:</b> 75% = \$494.40		
	ANKLE, Achille	s' tendon, operation for lengthening (Anaes.) (Assist.)		
49727	<b>Fee:</b> \$282.35	<b>Benefit:</b> 75% = \$211.80		
	-	ning of the gastrocnemius aponeurosis and soleus fascia, dren with cerebral palsy (Anaes.) (Assist.)	for the correction of equinus	
49728	Fee: \$564.70	<b>Benefit:</b> 75% = \$423.55		
		FOOT		
	FOOT, flexor or	extensor tendon, primary repair of (Anaes.)		
49800	Fee: \$131.85	<b>Benefit:</b> 75% = \$98.90 85% = \$112.10		
	FOOT, flexor or	extensor tendon, secondary repair of (Anaes.)		
49803	Fee: \$169.50	<b>Benefit:</b> 75% = \$127.15 85% = \$144.10		
	FOOT, subcutant	eous tenotomy of, 1 or more tendons (Anaes.)		
49806	Fee: \$131.85	<b>Benefit:</b> 75% = \$98.90 85% = \$112.10		
	FOOT, open tend	otomy of, with or without tenoplasty (Anaes.)		
49809	Fee: \$216.50	<b>Benefit:</b> 75% = \$162.40		
	FOOT, tendon or applies (Anaes.)	ligament transplantation of, not being a service to which (Assist.)	another item in this Group	
49812	Fee: \$432.95	<b>Benefit:</b> 75% = \$324.75		
	FOOT, triple arth	prodesis of, with synovectomy if performed (Anaes.) (Ass	sist.)	
49815	Fee: \$753.25	<b>Benefit:</b> 75% = \$564.95		
	FOOT, excision of calcaneal spur (Anaes.) (Assist.)			
49818	Fee: \$272.95	<b>Benefit:</b> 75% = \$204.75		
	FOOT, correction	n of hallux valgus or hallux rigidus by excision arthroplas ateral (Anaes.) (Assist.)	sty (Keller's or similar	
49821	Fee: \$432.95	<b>Benefit:</b> 75% = \$324.75		

T8. SUF		DNS 15. ORTHOPAEDIC
		of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar eral (Anaes.) (Assist.)
49824	Fee: \$757.95	<b>Benefit:</b> 75% = \$568.50
	FOOT, correction	of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.)
49827	Fee: \$470.70	<b>Benefit:</b> 75% = \$353.05
	FOOT, correction	of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.)
49830	Fee: \$823.75	<b>Benefit:</b> 75% = \$617.85
		of hallux valgus by osteotomy of first metatarsal with or without internal fixation and cision of exostoses associated with the first metatarsophalangeal joint - unilateral
49833	Fee: \$517.80	<b>Benefit:</b> 75% = \$388.35
		of hallux valgus by osteotomy of first metatarsal with or without internal fixation and cision of exostoses associated with the first metatarsophalangeal joint - bilateral
49836	Fee: \$894.40	<b>Benefit:</b> 75% = \$670.80
	tendon, with or w	of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus thout internal fixation and with or without excision of exostoses associated with the langeal joint - unilateral (Anaes.) (Assist.)
49837	Fee: \$647.25	<b>Benefit:</b> 75% = \$485.45
	tendon, with or w	of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus thout internal fixation and with or without excision of exostoses associated with the langeal joint - bilateral (Anaes.) (Assist.)
49838	Fee: \$1,117.75	<b>Benefit:</b> 75% = \$838.35
	FOOT, correction (Assist.)	of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.)
49839	Fee: \$517.80	<b>Benefit:</b> 75% = \$388.35
	FOOT, correction (Assist.)	of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.)
49842	Fee: \$894.40	<b>Benefit:</b> 75% = \$670.80
	FOOT, arthrodes	s of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.
49845	Fee: \$470.70	<b>Benefit:</b> 75% = \$353.05
	FOOT, correction	of claw or hammer toe (Anaes.)
49848	Fee: \$160.05	<b>Benefit:</b> 75% = \$120.05 85% = \$136.05
	FOOT, correction	of claw or hammer toe with internal fixation (Anaes.)
49851	Fee: \$207.00	<b>Benefit:</b> 75% = \$155.25
	FOOT, radical pl	ntar fasciotomy or fasciectomy of (Anaes.) (Assist.)
49854	Fee: \$376.55	<b>Benefit:</b> 75% = \$282.45

T8. SUF		TIONS 15. ORTHOPAEDIC
	FOOT, metatars	o-phalangeal joint replacement (Anaes.) (Assist.)
49857	Fee: \$348.35	<b>Benefit:</b> 75% = \$261.30
	FOOT, synovec	tomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)
49860	Fee: \$282.35	<b>Benefit:</b> 75% = \$211.80
	FOOT, synovec	tomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)
49863	Fee: \$423.75	<b>Benefit:</b> 75% = \$317.85
	FOOT, neurecto	omy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)
49866	Fee: \$301.05	<b>Benefit:</b> 75% = \$225.80
	-	INOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or each attendance (Anaes.)
49878	Fee: \$56.50	<b>Benefit:</b> 75% = \$42.40 85% = \$48.05
		OTHER JOINTS
		tic arthroscopy of (including biopsy), not being a service to which another item in this nd not being a service associated with any other arthroscopic procedure (Anaes.)
50100	Fee: \$272.95	<b>Benefit:</b> 75% = \$204.75 85% = \$232.05
	JOINT, arthroso (Assist.)	copic surgery of, not being a service to which another item in this Group applies (Anaes.)
50102	Fee: \$611.90	<b>Benefit:</b> 75% = \$458.95
	JOINT, arthroto	my of, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50103	Fee: \$329.60	<b>Benefit:</b> 75% = \$247.20
	JOINT, synoved (Assist.)	ctomy of, not being a service to which another item in this Group applies (Anaes.)
50104	Fee: \$312.30	<b>Benefit:</b> 75% = \$234.25 85% = \$265.50
		tion of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, ice to which another item in this Group applies (Anaes.) (Assist.)
50106	Fee: \$470.70	<b>Benefit:</b> 75% = \$353.05
		esis of, not being a service to which another item in this Group applies, with performed (Anaes.) (Assist.)
50109	Fee: \$470.70	<b>Benefit:</b> 75% = \$353.05
		FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving nan skin and subcutaneous tissue, not being a service to which another item in this Group (Assist.)
50112	Fee: \$361.05	<b>Benefit:</b> 75% = \$270.80
		TS, manipulation of, performed in the operating theatre of a hospital, not being a service a service to which another item in this Group applies (Anaes.)
50115	Fee: \$142.95	<b>Benefit:</b> 75% = \$107.25

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	SUBTALAR JOINT, arthrodesis of, with synovectomy if perfor	rmed (Anaes.) (Assist.)
50118	<b>Fee:</b> \$432.95 <b>Benefit:</b> 75% = \$324.75	
	GREATER TROCHANTER, transplantation of ileopsoas tendo	n to (Anaes.) (Assist.)
50121	<b>Fee:</b> \$847.35 <b>Benefit:</b> 75% = \$635.55	
	JOINT OR JOINTS, arthroplasty of, by any technique not being (Anaes.) (Assist.)	a service to which another item applies
50127	<b>Fee:</b> \$702.50 <b>Benefit:</b> 75% = \$526.90	
	JOINT OR JOINTS, application of external fixator to, other that (Assist.)	n for treatment of fractures (Anaes.)
50130	<b>Fee:</b> \$312.30 <b>Benefit:</b> 75% = \$234.25	
	MALIGNANT DISEASE	
	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OF biopsy of (not including aftercare) (Anaes.)	R DEEP SOFT TISSUE TUMOUR,
50200	<b>Fee:</b> \$188.20 <b>Benefit:</b> 75% = \$141.15 85% = \$160.00	
	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OF involving neurovascular structures, open biopsy of (not includin	
50201	<b>Fee:</b> \$329.50 <b>Benefit:</b> 75% = \$247.15	
	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, le (Assist.)	sional or marginal excision of (Anaes.)
50203	<b>Fee:</b> \$414.25 <b>Benefit:</b> 75% = \$310.70 85% = \$352.15	
	BONE TUMOUR, lesional or marginal excision of, combined v autograft, allograft or cementation (Anaes.) (Assist.)	vith any 1 of: liquid nitrogen freezing,
50206	<b>Fee:</b> \$611.90 <b>Benefit:</b> 75% = \$458.95	
	BONE TUMOUR, lesional or marginal excision of, combined w freezing, autograft, allograft or cementation (Anaes.) (Assist.)	vith any 2 or more of: liquid nitrogen
50209	<b>Fee:</b> \$753.25 <b>Benefit:</b> 75% = \$564.95	
	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR af enbloc resection of, with compartmental or wide excision of sof (Assist.)	
50212	<b>Fee:</b> \$1,647.55 <b>Benefit:</b> 75% = \$1235.70	
	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR af enbloc resection of, with compartmental or wide excision of sof (prosthesis, allograft or autograft) (Anaes.) (Assist.)	
50215	<b>Fee:</b> \$2,071.20 <b>Benefit:</b> 75% = \$1553.40	
	MALIGNANT TUMOUR of LONG BONE, enbloc resection or adjacent joint, with synovectomy if performed (Anaes.) (Assist.	
50218	<b>Fee:</b> \$2,730.30 <b>Benefit:</b> 75% = \$2047.75	
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of	PELVIS, SACRUM or SPINE; or

T8. SUF		DNS 15. ORTHOPAEDIC
	SCAPULA and SI	HOULDER, enbloc resection of (Anaes.) (Assist.)
	Fee: \$2,541.85	<b>Benefit:</b> 75% = \$1906.40
		AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or HOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or (Assist.)
50224	Fee: \$2,824.35	<b>Benefit:</b> 75% = \$2118.30 85% = \$2742.65
		ONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or without prosthetic replacement (Anaes.) (Assist.)
50227	Fee: \$3,295.10	<b>Benefit:</b> 75% = \$2471.35
	BENIGN TUMOU (Anaes.) (Assist.)	JR, resection of, requiring anatomic specific allograft, with or without internal fixation
50230	Fee: \$1,694.60	<b>Benefit:</b> 75% = \$1270.95
	MALIGNANT TU	JMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.)
50233	Fee: \$2,165.35	<b>Benefit:</b> 75% = \$1624.05
	MALIGNANT TU femur (Anaes.) (A	JMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third ssist.)
50236	Fee: \$1,694.60	<b>Benefit:</b> 75% = \$1270.95
	MALIGNANT TU applies (Anaes.) (A	JMOUR, amputation for, not being a service to which another item in this Group Assist.)
50239	Fee: \$1,129.65	<b>Benefit:</b> 75% = \$847.25
		LIMB LENGTHENING AND DEFORMITY CORRECTION
		ITY, slow correction of, using ring fixator or similar device, including all associated ble only once in any 12 month period (Anaes.) (Assist.)
50300	Fee: \$1,157.70	<b>Benefit:</b> 75% = \$868.30
		NING, 5cm or less, by gradual distraction, with application of an external fixator or voice, in the operating theatre of a hospital - payable only once per limb in any 12 aes.) (Assist.)
50303	Fee: \$1,580.60	<b>Benefit:</b> 75% = \$1185.45
		NING , where the lengthening is bipolar, or bone transport is performed or where the to correct an adjacent joint deformity, or where the lengthening is greater than 5cm
50306	Fee: \$2,467.90	<b>Benefit:</b> 75% = \$1850.95 85% = \$2386.20
	fixation pins, perfe	OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of ormed under general anaesthesia in the operating theatre of a hospital, not being a em 50303 or 50306 applies (Anaes.) (Assist.)
50309	Fee: \$305.05	<b>Benefit:</b> 75% = \$228.80
		comy of, by arthroscopic or open means - not associated with any other arthroscopic nkle (Anaes.) (Assist.)
50312	Fee: \$700.10	<b>Benefit:</b> 75% = \$525.10

T8. SUF	GICAL OPERATI	ONS	15. ORTHOPAEDIC
	TALIPES EQUI	NOVARUS, posterior release of (A	naes.) (Assist.)
50315	Fee: \$693.30	<b>Benefit:</b> 75% = \$520.00	
	TALIPES EQUI	NOVARUS, medial release of (Ana	es.) (Assist.)
50318	Fee: \$693.30	<b>Benefit:</b> 75% = \$520.00	
	TALIPES EQUI	NOVARUS, combined postero-med	ial release of (Anaes.) (Assist.)
50321	Fee: \$928.85	<b>Benefit:</b> 75% = \$696.65	
	TALIPES EQUI	NOVARUS, combined postero-med	ial release of, revision procedure (Anaes.) (Assist.)
50324	Fee: \$1,324.15	<b>Benefit:</b> 75% = \$993.15	
	TALIPES EQUI	NOVARUS, bilateral procedures (A	naes.) (Assist.)
50327	Fee: \$1,615.15	<b>Benefit:</b> 75% = \$1211.40	
	plaster, performe		nital - post operative manipulation and change of perating theatre of a hospital, not being a service to oplies (Anaes.)
50330	Fee: \$228.70	<b>Benefit:</b> 75% = \$171.55	
	TARSAL COAL (Assist.)	ITION, excision of, with interpositi	on of muscle, fat graft or similar graft (Anaes.)
50333	Fee: \$616.85	<b>Benefit:</b> 75% = \$462.65	
	TALUS, VERTIO (Assist.)	CAL, CONGENITAL, combined an	terior and posterior reconstruction (Anaes.)
50336	Fee: \$922.05	<b>Benefit:</b> 75% = \$691.55	
	FOOT AND AND (Assist.)	KLE, tibialis anterior tendon (split o	or whole) transfer to lateral column (Anaes.)
50339	Fee: \$561.55	<b>Benefit:</b> 75% = \$421.20	
		KLE, tibialis or tibialis posterior ter ior aspect of foot (Anaes.) (Assist.)	ndon transfer, through the interosseous membrane to
50342	Fee: \$651.60	<b>Benefit:</b> 75% = \$488.70	
		SION DEFORMITY OF TOE, relea and release of capsule contracture (	se incorporating V-Y plasty of skin, lengthening of Anaes.) (Assist.)
50345	Fee: \$346.65	<b>Benefit:</b> 75% = \$260.00	
		HIP, KNEE AND L	EG PROCEDURES
		of, post-operative manipulation an e operating theatre of a hospital (An	d change of plaster, performed under general naes.)
50348	Fee: \$228.70	<b>Benefit:</b> 75% = \$171.55	
	HIP, congenital d	islocation of, treatment of, by close	d reduction (Anaes.)
50349	Fee: \$320.15	<b>Benefit:</b> 75% = \$240.15 85% =	\$272.15

T8. SUF	RGICAL OPERATIO	ONS 15. ORTHOPAEDIC
	HIP, development	al dislocation of, open reduction of (Anaes.) (Assist.)
50351	Fee: \$1,597.25	<b>Benefit:</b> 75% = \$1197.95
	HIP, congenital di attendance (Anaes	slocation of, treatment of, involving supervision of splint, harness or cast - each
50352	Fee: \$56.50	<b>Benefit:</b> 75% = \$42.40 85% = \$48.05
	HIP SPICA, initia (Assist.)	l application of, for congenital dislocation of hip (excluding aftercare) (Anaes.)
50353	Fee: \$354.80	<b>Benefit:</b> 75% = \$266.10
	TIBIA, pseudarth	rosis of, congenital, resection and internal fixation (Anaes.) (Assist.)
50354	Fee: \$1,310.15	<b>Benefit:</b> 75% = \$982.65 85% = \$1228.45
	KNEE, LEG OR (Anaes.) (Assist.)	THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer
50357	Fee: \$561.55	<b>Benefit:</b> 75% = \$421.20
	KNEE, LEG OR	THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.)
50360	Fee: \$651.60	<b>Benefit:</b> 75% = \$488.70
	KNEE, contractur (Anaes.) (Assist.)	e of, posterior release involving multiple tendon lengthening or tenotomies, unilateral
50363	Fee: \$499.05	<b>Benefit:</b> 75% = \$374.30
	KNEE, contractur (Anaes.) (Assist.)	e of, posterior release involving multiple tendon lengthening or tenotomies, bilateral
50366	Fee: \$873.45	<b>Benefit:</b> 75% = \$655.10
		e of, posterior release involving multiple tendon lengthening with or without lease of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.)
50369	Fee: \$651.60	<b>Benefit:</b> 75% = \$488.70
		e of, posterior release involving multiple tendon lengthening with or without lease of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.)
50372	Fee: \$1,143.80	<b>Benefit:</b> 75% = \$857.85
		of, medial release, involving lengthening of, or division of the adductors and psoas with n of the obturator nerve, unilateral (Anaes.) (Assist.)
50375	Fee: \$499.05	<b>Benefit:</b> 75% = \$374.30
		of, medial release, involving lengthening of, or division of the adductors and psoas with n of the obturator nerve, bilateral (Anaes.) (Assist.)
50378	Fee: \$873.45	<b>Benefit:</b> 75% = \$655.10
		of, anterior release, involving lengthening of, or division of the hip flexors and psoas vision of the joint capsule, unilateral (Anaes.) (Assist.)
50381	Fee: \$651.60	<b>Benefit:</b> 75% = \$488.70
50384	HIP, contracture of	of, anterior release, involving lengthening of, or division of the hip flexors and psoas

T8. SUR	GICAL OPERATIO	DNS	15. ORTHOPAEDIC
	with or without div	vision of the joint capsule, bilateral (Anaes.)	(Assist.)
	Fee: \$1,143.80	<b>Benefit:</b> 75% = \$857.85	
	· •	lon transfer to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.	e
50387	Fee: \$651.60	<b>Benefit:</b> 75% = \$488.70	
		BRAL PALSY, or other neuromuscular cond under general anaesthesia, performed in the	
50390	Fee: \$228.70	<b>Benefit:</b> 75% = \$171.55	
	PELVIS, bone grat	ft or shelf procedures for acetabular dysplasia	a (Anaes.) (Assist.)
50393	Fee: \$845.60	<b>Benefit:</b> 75% = \$634.20	
		DYSPLASIA, treatment of, by multiple peri-a formed (Anaes.) (Assist.)	acetabular osteotomy, including internal
50394	Fee: \$2,777.30	<b>Benefit:</b> 75% = \$2083.00	
		SHOULDER, ARM AND FOREARM	PROCEDURES
	phalanges, with lig	abnormalities or duplication of digits, ampu ament or joint reconstruction (Anaes.) (Assis	
50396	Fee: \$464.55	<b>Benefit:</b> 75% = \$348.45	
	(Anaes.) (Assist.)	IAL APLASIA OR DYSPLASIA (radial clu	b hand), centralisation or radialisation of
50399	Fee: \$922.05	<b>Benefit:</b> 75% = \$691.55	
	TORTICOLLIS, b (Assist.)	ipolar release of sternocleidomastoid muscle	and associated soft tissue (Anaes.)
50402	Fee: \$422.95	<b>Benefit:</b> 75% = \$317.25	
	ELBOW, flexorpla	asty, or tendon transfer to restore elbow funct	tion (Anaes.) (Assist.)
50405	Fee: \$575.40	<b>Benefit:</b> 75% = \$431.55	
	SHOULDER, cong	genital or developmental dislocation, open re	duction of (Anaes.) (Assist.)
50408	Fee: \$998.25	<b>Benefit:</b> 75% = \$748.70	
	AMPU	TATIONS OR RECONSTRUCTIONS FOR C	CONGENITAL DEFORMITIES
		EFICIENCY, treatment of congenital deficient al tibia followed by knee fusion (Anaes.) (Ass	
50411	Fee: \$1,310.15	<b>Benefit:</b> 75% = \$982.65 85% = \$1228.45	
		EFICIENCY, treatment of congenital deficient of the second	ncy of the femur by resection of the distal

T8. SUF	RGICAL OPERATI	ONS		15. ORTHOPAEDIC
	Fee: \$1,767.60	<b>Benefit:</b> 75% = \$1325	.70 85% = \$1685.90	
			of congenital deficiency of the t and repair of quadriceps mechan	
50417	Fee: \$1,310.15	<b>Benefit:</b> 75% = \$982.	55 85% = \$1228.45	
	PATELLA, conge	enital dislocation of, reco	nstruction of the quadriceps (An	aes.) (Assist.)
50420	Fee: \$1,081.35	<b>Benefit:</b> 75% = \$811.0	05	
	TIBIA, FIBULA fixation (Anaes.)		eficiency of, transfer of the fibul	a to tibia, with internal
50423	Fee: \$998.25	<b>Benefit:</b> 75% = \$748.	70 85% = \$916.55	
		TUM	IOROUS CONDITIONS	
			ion or lesions from bone - 1 app	roach (Anaes.) (Assist.)
50426	Fee: \$464.55	<b>Benefit:</b> 75% = \$348.4		
			IRGERY FOR CHILDREN WITH	
			LEVEL SURGERY for patients e or more of the following:	less than 18 years of age with
		g of one or more contractor actional lengthening or in	ed muscle tendon units by tendor tramuscular lengthening.	n lengthening, muscle
	(b) Correction of	of muscle imbalance by te	endon transfer/transfers.	
	(c) Correction of	of femoral torsion by rota	tional osteotomy of the femur.	
	(d) Correction of	of tibial torsion by rotatio	nal osteotomy of the tibia.	
		of joint instability by varu if performed, or os calci	s derotation osteotomy of the fe s lengthening.	mur, subtalar arthrodesis, with
	Conjoint surgery,	principal specialist surge	eon, including fluoroscopy and a	ftercare (Anaes.) (Assist.)
50450	(See para TN.8.118 <b>Fee:</b> \$1,226.90	of explanatory notes to this <b>Benefit:</b> 75% = \$920.2		
			LEVEL SURGERY for patients e or more of the following:	less than 18 years of age with
		g of one or more contractor ctional lengthening or int	ed muscle tendon units by tendor ramuscular lengthening.	n lengthening, muscle
	(b) Correction of	of muscle imbalance by te	endon transfer/transfers.	
	(c) Correction of	of femoral torsion by rota	tional osteotomy of the femur.	
	(d) Correction of	of tibial torsion by rotatio	nal osteotomy of the tibia.	
		of joint instability by varu if performed, or os calci	s derotation osteotomy of the fe s lengthening.	mur, subtalar arthrodesis, with
50451				

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy an (Assist.)	d excluding aftercare (Anaes.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,226.90 <b>Benefit:</b> 75% = \$920.20	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patien diplegic cerebral palsy that comprises:	ts less than 18 years of age with
	() Lengthening of one or more contracted muscle tendon units by ter recession, fractional lengthening or intramuscular lengthening.	ndon lengthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and	nd aftercare (Anaes.) (Assist.)
50455	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,389.40 <b>Benefit:</b> 75% = \$1042.05	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patien diplegic cerebral palsy that comprises:	tts less than 18 years of age with
	(a) Lengthening of one or more contracted muscle tendon units by ten recession, fractional lengthening or intramuscular lengthening.	ndon lengthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy an (Assist.)	d excluding aftercare (Anaes.)
50456	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,389.40 <b>Benefit:</b> 75% = \$1042.05	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patien diplegic cerebral palsy that comprises bilateral soft tissue surgery and b	
	() Lengthening of one or more contracted muscle tendon units by ter recession, fractional lengthening or intramuscular lengthening.	ndon lengthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(`) Correction of torsional abnormality of the femur by rotational oste	eotomy and internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and	nd aftercare (Anaes.) (Assist.)
50460	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,074.45 <b>Benefit:</b> 75% = \$1555.85	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patien diplegic cerebral palsy that comprises bilateral soft tissue surgery and b	
	(a) Lengthening of one or more contracted muscle tendon units by ter recession, fractional lengthening or intramuscular lengthening.	ndon lengthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of torsional abnormality of the femur by rotational oste	eotomy and internal fixation.
50461	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy an	d excluding aftercare (Anaes.)

T8. SUR	GICAL OPERATIONS 15. ORTHOPAEDIC
	(Assist.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,074.45 <b>Benefit:</b> 75% = \$1555.85
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(`) Correction of muscle imbalance by tendon transfer/transfers.
	(`) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.
	(`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
50465	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,921.80 <b>Benefit:</b> 75% = \$2191.35
	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.
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(b) Correction of muscle imbalance by tendon transfer/transfers.
	(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.
	(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)
50466	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,921.80 <b>Benefit:</b> 75% = \$2191.35
	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.
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(`) Correction of muscle imbalance by tendon transfer/transfers.
	(`) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.
	(`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.
50470	(`) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion.

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and a	ftercare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,705.55 <b>Benefit:</b> 75% = \$2779.20	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients le cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral foot stabilisation.	
	(a) Lengthening of one or more contracted muscle tendon units by tendor recession, fractional lengthening or intramuscular lengthening.	n lengthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of abnormal torsion of the femur by rotational osteotomy	with internal fixation.
	(d) Correction of abnormal torsion of the tibia by rotational osteotomy w	vith internal fixation.
	(e) Correction of bilateral pes valgus by os calcis lengthening or subtalar	fusion.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and ex (Assist.)	xcluding aftercare (Anaes.)
50471	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,705.55 <b>Benefit:</b> 75% = \$2779.20	
	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 year cerebral palsy for the correction of crouch gait including:	ars of age with diplegic
	(`) Lengthening of one or more contracted muscle tendon units by tendor recession, fractional lengthening or intramuscular lengthening.	n lengthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(`) Correction of flexion deformity at the knee by extension osteotomy o internal fixation.	f the distal femur including
	(`) Correction of patella alta and quadriceps insufficiency by patella tend	on shortening/reconstruction.
	(`) Correction of tibial torsion by rotational osteotomy of the tibia with in	nternal fixation.
	(`) Correction of foot instability by os calcis lengthening or subtalar fusio	on.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and a	aftercare (Anaes.) (Assist.)
50475	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,275.85 <b>Benefit:</b> 75% = \$3206.90	
	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 year cerebral palsy for the correction of crouch gait including:	ars of age with diplegic
	(a) Lengthening of one or more contracted muscle tendon units by tendo recession, fractional lengthening or intramuscular lengthening.	n lengthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
50476	(c) Correction of flexion deformity at the knee by extension osteotomy of	f the distal femur including

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	internal fixation.	
	(d) Correction of patella alta and quadriceps insufficiency by patella tendon	shortening/reconstruction.
	(e) Correction of tibial torsion by rotational osteotomy of the tibia with inte	rnal fixation.
	(f) Correction of foot instability by os calcis lengthening or subtalar fusion.	
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclu(Assist.)	uding aftercare (Anaes.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,275.85 <b>Benefit:</b> 75% = \$3206.90	
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIE	ENTS
	RADIUS OR ULNA, distal end of, <i>with open growth plate</i> , treatment of fract (Anaes.)	ure of, by closed reduction
50500	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$276.65 <b>Benefit:</b> 75% = \$207.50 85% = \$235.20	
	RADIUS OR ULNA, distal end of, <i>with open growth plate</i> , treatment of fract (Anaes.) (Assist.)	ture of, by open reduction
50504	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$369.05 <b>Benefit:</b> 75% = \$276.80 85% = \$313.70	
	RADIUS, distal end of, <i>with open growth plate</i> , treatment of Colles', Smith's closed reduction (Anaes.)	or Barton's fracture, by
50508	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$395.25 <b>Benefit:</b> 75% = \$296.45 85% = \$336.00	
	RADIUS, distal end of, <i>with open growth plate</i> , treatment of Colles', Smith's open reduction (Anaes.) (Assist.)	or Barton's fracture of, by
50512	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$527.30 <b>Benefit:</b> 75% = \$395.50	
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of undertaken in the operating theatre of a hospital (Anaes.)	of, by closed reduction
50516	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$355.85 <b>Benefit:</b> 75% = \$266.90	
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of (Anaes.) (Assist.)	of, by open reduction
50520	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$474.40 <b>Benefit:</b> 75% = \$355.80	
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeaz closed reduction undertaken in the operating theatre of a hospital (Anaes.) (A	zi or Monteggia injury), by
50524	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$408.50 <b>Benefit:</b> 75% = \$306.40	
50528	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeaz	

T8. SUF	RGICAL OPERATIONS 15. ORTHOPA	EDIC
	reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)	
	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$659.00 <b>Benefit:</b> 75% = \$494.25	
	RADIUS AND ULNA, shafts of, <i>with open growth plates</i> , treatment of fracture of, by closed reduce undertaken in the operating theatre of a hospital (Anaes.)	ction
50532	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$573.40 <b>Benefit:</b> 75% = \$430.05	
	RADIUS AND ULNA, shafts of, <i>with open growth plates</i> , treatment of fracture of, by open reducti (Anaes.) (Assist.)	ion
50536	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$764.40 <b>Benefit:</b> 75% = \$573.30	
	OLECRANON, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist	st.)
50540	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$527.30 <b>Benefit:</b> 75% = \$395.50	
	RADIUS, <i>with open growth plate</i> , treatment of fracture of head or neck of, by closed reduction of (Anaes.)	
50544	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$263.60 <b>Benefit:</b> 75% = \$197.70 85% = \$224.10	
	RADIUS, with open growth plate, treatment of fracture of head or neck of, by reduction with or winternal fixation by open or percutaneous means (Anaes.) (Assist.)	thout
50548	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$527.30 <b>Benefit:</b> 75% = \$395.50	
	HUMERUS, proximal, <i>with open growth plate</i> , treatment of fracture of, by closed reduction, under in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	taken
50552	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$454.75 <b>Benefit:</b> 75% = \$341.10	
	HUMERUS, proximal, <i>with open growth plate</i> , treatment of fracture of, by open reduction (Anaes. (Assist.)	)
50556	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$606.20 <b>Benefit:</b> 75% = \$454.65	
	HUMERUS, shaft of, <i>with open growth plate</i> , treatment of fracture of, by closed reduction, underta in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	aken
50560	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$474.40 <b>Benefit:</b> 75% = \$355.80	
	HUMERUS, shaft of, <i>with open growth plate</i> , treatment of fracture of, by internal or external fixati (Anaes.) (Assist.)	ion
50564	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$632.65 <b>Benefit:</b> 75% = \$474.50	
	HUMERUS, <i>with open growth plate</i> , supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	1
50568	(See para TN.8.119, TN.8.118 of explanatory notes to this Category)	

T8. SUF	GICAL OPERATIONS	15. ORTHOPAEDIC
	<b>Fee:</b> \$553.60 <b>Benefit:</b> 75% = \$415.2	20
		acondylar or condylar, treatment of fracture of, by reduction r percutaneous means, undertaken in the operating theatre of a
50572	(See para TN.8.119, TN.8.118 of explanatory n <b>Fee:</b> \$738.10 <b>Benefit:</b> 75% = \$553.0	
	FEMUR, <i>with open growth plate</i> , treatmen (Assist.)	t of fracture of, by closed reduction or traction (Anaes.)
50576	(See para TN.8.119, TN.8.118 of explanatory m <b>Fee:</b> \$606.20 <b>Benefit:</b> 75% = \$454.0	
		condyles, medial or lateral, treatment of fracture of, by by open or percutaneous means (Anaes.) (Assist.)
50580	(See para TN.8.119, TN.8.118 of explanatory n <b>Fee:</b> \$632.65 <b>Benefit:</b> 75% = \$474.3	
	TIBIA, distal, <i>with open growth plate</i> , trea fixation by open or percutaneous means (A	tment of fracture of, by reduction with or without internal anaes.) (Assist.)
50584	(See para TN.8.119, TN.8.118 of explanatory m Fee: \$606.20 Benefit: 75% = \$454.6	
	TIBIA AND FIBULA, with open growth p (Assist.)	blates, treatment of fracture of, by internal fixation (Anaes.)
50588	(See para TN.8.119, TN.8.118 of explanatory n Fee: \$790.70 Benefit: 75% = \$593.0	
	SPINE SURGERY FOR SCOLI	OSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
	SCOLIOSIS OR KYPHOSIS, in a growin localiser cast, under general anaesthesia, in	g child, manipulation of deformity and application of a a hospital (Anaes.) (Assist.)
50600	(See para TN.8.118 of explanatory notes to this <b>Fee:</b> \$434.70 <b>Benefit:</b> 75% = \$326.0	
	SCOLIOSIS or KYPHOSIS, in a child or (Anaes.) (Assist.)	adolescent, spinal fusion for (without instrumentation)
50604	(See para TN.8.118 of explanatory notes to this <b>Fee:</b> \$1,845.05 <b>Benefit:</b> 75% = \$1383	
		adolescent, treatment by segmental instrumentation and which item 48642 to 48675 applies (Anaes.) (Assist.)
50608	(See para TN.8.118 of explanatory notes to this <b>Fee:</b> \$3,426.95 <b>Benefit:</b> 75% = \$2570	
		adolescent, with spinal deformity, treatment by segmental and posterior approaches, not being a service to which item
50612	(See para TN.8.118 of explanatory notes to this <b>Fee:</b> \$4,874.50 <b>Benefit:</b> 75% = \$3655	
50616	SCOLIOSIS, in a child or adolescent, re-e instrumentation used for correction of spin	xploration for adjustment or removal of segmental e deformity (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	(See para TN.8.118 of explanatory notes to this Category)Fee: $$619.35$ Benefit: $75\% = $464.55$
	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.)
50620	(See para TN.8.118 of explanatory notes to this Category)Fee: $$3,426.95$ Benefit: $75\% = $2570.25$
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Anaes.) (Assist.)
50624	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,426.95 <b>Benefit:</b> 75% = \$2570.25
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.)
50628	(See para TN.8.118 of explanatory notes to this Category)Fee: $$4,233.20$ Benefit: $75\% = $3174.90$
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.)
50632	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,558.65 <b>Benefit:</b> 75% = \$2669.00
	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.)
50636	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,954.10 <b>Benefit:</b> 75% = \$2965.60
	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.)
50640	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,185.80 <b>Benefit:</b> 75% = \$1639.35
	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.)
50644	(See para TN.8.118 of explanatory notes to this Category)Fee: $$2,108.95$ Benefit: $75\% = $1581.75$
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS
	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.)
50650	(See para TN.8.118 of explanatory notes to this Category)           Fee: \$414.75         Benefit: 75% = \$311.10         85% = \$352.55
	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.)
50654	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$496.65 <b>Benefit:</b> 75% = \$372.50

T8. SUP	RGICAL OPERATIONS	15. ORTHOPAEDIC
	HIP DYSPLASIA or DISLOCATION, in a anaesthesia (Anaes.)	child, examination and manipulation of the hip under
50658	(See para TN.8.118 of explanatory notes to this <b>C</b> <b>Fee:</b> \$197.75 <b>Benefit:</b> 75% = \$148.35	
T8. SUF	<b>RGICAL OPERATIONS</b>	16. RADIOFREQUENCY AND MICROWAVE TISSUE ABLATION
	Group T8. Surgical Operations	
	Subgroup 16. Radiof	equency And Microwave Tissue Ablation
		he liver, destruction of, by percutaneous radiofrequency blation (including any associated imaging services), other hich item 30419 or 50952 applies
	(Anaes.)	
50950	<b>Fee:</b> \$817.10 <b>Benefit:</b> 75% = \$612.85	85% = \$735.40
	radiofrequency ablation or open or laparosco imaging services), if a multi-disciplinary tea	he liver, destruction of, by open or laparoscopic opic microwave tissue ablation (including any associated m has assessed that percutaneous radiofrequency ablation or not be performed or is not practical because of one or more
	(a) percutaneous access cannot be achieved;	
	(b) vital organs or tissues are at risk of dama percutaneous microwave tissue ablation pro	ge from the percutaneous radiofrequency ablation or cedure;
		ble, however there is at least one primary liver tumour in an ble for radiofrequency ablation or microwave tissue ablation;
	other than a service associated with a servic	e to which item 30419 or 50950 applies.
	(Anaes.)	
50952	(See para TN.8.120 of explanatory notes to this <b>G</b> Fee: \$817.10 <b>Benefit:</b> 75% = \$612.85	
T9. ASS	SISTANCE AT OPERATIONS	
	Group T9. Assistance At Operations	
		word "Assist." for which the fee does not exceed \$558.30 lentified by the word "Assist." where the fee for the series or word "Assist." does not exceed \$558.30
51300	(See para TN.9.2, TN.9.1 of explanatory notes to <b>Fee:</b> \$86.30 <b>Benefit:</b> 75% = \$64.75	
51303	Assistance at any operation identified by the	word "Assist." for which the fee exceeds \$558.30 or at a

T9. ASS	SISTANCE AT OPERATIONS
	series of operations identified by the word "Assist." for which the aggregate fee exceeds \$558.30.
	(See para TN.9.1, TN.9.3 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the operation or combination of operations
	Assistance at a birth involving Caesarean section
51306	(See para TN.9.1 of explanatory notes to this Category)           Fee: \$124.65         Benefit: 75% = \$93.50         85% = \$106.00
	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a birth involving Caesarean section
51309	(See para TN.9.1, TN.9.4 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627
51312	(See para TN.4.11, TN.9.1 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the procedure or combination of procedures
	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779
51315	(See para TN.9.1 of explanatory notes to this Category)         Fee: \$272.40       Benefit: 75% = \$204.30       85% = \$231.55
	Assistance at cataract and intraocular lens surgery where patient has:
	- total loss of vision, including no potential for central vision, in the fellow eye; or
	- previous significant surgical complication in the fellow eye; or
- pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, cornea pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's sync homocysteinuria or previous blunt trauma causing intraocular damage	
51318	(See para TN.9.5, TN.9.1 of explanatory notes to this Category)         Fee: \$179.75       Benefit: 75% = \$134.85       85% = \$152.80
ANAES ONLY P PERFOR	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 1. HEAD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 1. Head
	Subgroup 1. Head           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)

ANAES	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA
	RMED IN ASSOCIATION WITH AN LE SERVICE 1. HEAD
	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units)
20102	Fee: \$118.80         Benefit: 75% = \$89.10         85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units)
20104	Fee: \$79.20         Benefit: 75% = \$59.40         85% = \$67.35
	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)
20120	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units)
20124	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units)
20140	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (6 basic units)
20142	Fee: \$118.80         Benefit: 75% = \$89.10         85% = \$101.00           Extended Medicare Safety Net Cap: \$95.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units)
20143	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (8 basic units)
20144	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65
20111	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (8 basic units)
20145	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65
20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units)
20146	Fee:         \$99.00         Benefit:         75% = \$74.25         85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units)
20147	Fee: \$118.80         Benefit: 75% = \$89.10         85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units)
20148	Fee: \$79.20         Benefit: 75% = \$59.40         85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nose or accessory sinuses,
	not being a service to which another item in this Subgroup applies (6 basic units)
20160	Fee: \$118.80         Benefit: 75% = \$89.10         85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on the nose and accessory sinuses (7 basic units)
20162	<b>Fee:</b> \$138.60 <b>Benefit:</b> 75% = \$103.95 85% = \$117.85

ANAES ONLY F PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 1. HEAD
	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units)
20164	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units)
20170	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units)
20172	<b>Fee:</b> \$138.60 <b>Benefit:</b> 75% = \$103.95 85% = \$117.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units)
20174	<b>Fee:</b> \$178.20 <b>Benefit:</b> 75% = \$133.65 85% = \$151.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)
20176	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units)
20190	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units)
20192	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units)
20210	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units)
20212	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units)
20214	<b>Fee:</b> \$178.20 <b>Benefit:</b> 75% = \$133.65 85% = \$151.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units)
20216	<b>Fee:</b> \$396.00 <b>Benefit:</b> 75% = \$297.00 85% = \$336.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units)
20220	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
20222	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units)

T10. RE	ELATIVE VALUE GUIDE FOR	
	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA	
	RMED IN ASSOCIATION WITH AN	
ELIGIBI	LE SERVICE 1. HE	EAD
	Fee: \$118.80         Benefit: 75% = \$89.10         85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic ur	nits)
20225	<b>Fee:</b> \$237.60 <b>Benefit:</b> 75% = \$178.20 85% = \$202.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the head or face (12 basic units)	
20230	(See para TN.10.28 of explanatory notes to this Category)Fee: $$237.60$ Benefit: $75\% = $178.20$ $85\% = $202.00$	
ANAES ONLY P PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 2. NE	ECK
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 2. Neck	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units)	3
20300	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for incision and drainage of large haemator large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units)	
20305	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on oesophagus, thyroid, lary 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)	ynx,
20320	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units)	
20321	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding r and mouth) (8 basic units)	nose
20330	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, no being a service to which another item in this Subgroup applies (10 basic units)	ot
20350	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
20352	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck	k (5

ANAES ONLY F	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEF PAYABLE FOR ANAESTHESI RMED IN ASSOCIATION WIT	Α
	LE SERVICE	2. NECK
	basic units)	
	Fee: \$99.00 Benefit:	75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEM involving the neck (12 basic un	IENT OF ANAESTHESIA for microvascular free tissue flap surgery nits)
20355	(See para TN.10.28 of explanator Fee: \$237.60 Benefit:	y notes to this Category) 75% = \$178.20
ANAES ONLY F PERFO		A 'H AN 3. THORAX uide For Anaesthesia - Medicare Benefits Are Only Payable For
	Anaesthesia Performed In As	Subgroup 2 Therew
		Subgroup 3. Thorax
		IENT OF ANAESTHESIA for procedures on the skin or subcutaneous e chest, not being a service to which another item in this Subgroup applies
20400	<b>Fee:</b> \$59.40 <b>Benefit:</b> 7	75% = \$44.55 85% = \$50.50
		IENT OF ANAESTHESIA for procedures on the breast, not being a in this Subgroup applies (4 basic units)
20401	Fee: \$79.20 Benefit:	75% = \$59.40 $85% = $67.35$
	INITIATION OF MANAGEM basic units)	IENT OF ANAESTHESIA for reconstructive procedures on breast (5
20402	Fee: \$99.00 Benefit:	75% = \$74.25 85% = \$84.15
		IENT OF ANAESTHESIA for removal of breast lump or for breast node dissection is performed (5 basic units)
20403	Fee: \$99.00 Benefit:	75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEM	IENT OF ANAESTHESIA for mastectomy (6 basic units)
20404	<b>Fee:</b> \$118.80 <b>Benefit:</b> 7	75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEM using myocutaneous flaps (8 b	IENT OF ANAESTHESIA for reconstructive procedures on the breast asic units)
20405	<b>Fee:</b> \$158.40 <b>Benefit:</b> 7	75% = \$118.80 85% = \$134.65
	INITIATION OF MANAGEN	
		IENT OF ANAESTHESIA for radical or modified radical procedures on node dissection (13 basic units)
20406	breast with internal mammary	-

ELIGIBI	LE SERVICE	3. THORAX
	basic units)	
	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous terior part of the chest not being a service to which another item in this Subgroup applie
20420	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION O sternum (4 basic	F MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the cunits)
20440	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum ice to which another item in this Subgroup applies (5 basic units)
20450	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION O sternum (6 basic	F MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or cunits)
20452	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
		F MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to the term in this Subgroup applies (6 basic units)
20470	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)
20472	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic
20474	(See para TN.10.2 <b>Fee:</b> \$257.40	22 of explanatory notes to this Category) <b>Benefit:</b> $75\% = \$193.05$ $85\% = \$218.80$
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery terior or posterior thorax (10 basic units)
20475	(See para TN.10.2 <b>Fee:</b> \$198.00	28 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
ANAES ONLY F	AYABLE FOR A	ARE BENEFITS ARE
	LE SERVICE	4. INTRATHORACIO
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 4. Intrathoracic

Subgroup 4. Intrathoracic

ANAES ONLY F	PAYABLE FOR A	ARE BENEFITS ARE	
	LE SERVICE	4. INTRATHORACIC	
	INITIATION OI basic units)	F MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15	
20500	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45	
		F MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid or bronchoscopy), not being a service to which another item in this Subgroup applies (6	
20520	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units)	
20522	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units)	
20524	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units)	
20526	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
20320		F MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units)	
20528	<b>Fee:</b> \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, m, or mediastinum, not being a service to which another item in this Subgroup applies	
20540	Fee: \$257.40	<b>Benefit:</b> 75% = \$193.05 85% = \$218.80	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units)	
20542	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45	
	INITIATION OI (15 basic units)	F MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty	
20546	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45	
	INITIATION OI and bronchi (15	F MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea basic units)	
20548	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45	
	Initiation of the management of anaesthesia for:		
	(a) open procedu	ires on the heart, pericardium or great vessels of the chest; or	
	(b) percutaneous	insertion of a valvular prosthesis (20 basic units)	
20560	<b>Fee:</b> \$396.00	<b>Benefit:</b> 75% = \$297.00 85% = \$336.60	
20500			

ANAES ONLY P PERFO	AYABLE FOR A	ARE BENEFITS ARE
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 5. Spine And Spinal Cord
	not being a serv	F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, ice to which another item in this Subgroup applies (for myelography and discography 3 and 21914) (10 basic units)
20600	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ting position (13 basic units)
20604	Fee: \$257.40	<b>Benefit:</b> 75% = \$193.05 85% = \$218.80
		F MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, ice to which another item in this Subgroup applies (10 basic units)
20620	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION C units)	F MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic
20622	Fee: \$257.40	<b>Benefit:</b> 75% = \$193.05 85% = \$218.80
		F MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a n another item in this Subgroup applies (8 basic units)
20630	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units)
20632	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units)
20634	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord
20670	(See para TN.10.2 <b>Fee:</b> \$257.40	23 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$193.05 85% = \$218.80
		F MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in eatre of a hospital (3 basic units)
20680	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being ch another item in this Subgroup applies (5 basic units)
20690	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15

		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 6. Upper Abdomen
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous ber anterior abdominal wall, not being a service to which another item in this Subgroup units)
20700	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)
20702	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	tendons and fase	F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, cia of the upper abdominal wall, not being a service to which another item in this es (4 basic units)
20703	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery terior or posterior upper abdomen (10 basic units)
20704	(See para TN.10.2 <b>Fee:</b> \$198.00	28 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopy procedures (6 basic
20705	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
		F MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the upper eing a service to which another item in this Subgroup applies (7 basic units)
20706	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units)	
20730	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal en procedures (5 basic units)	
20740	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic ssociation with acute gastrointestinal haemorrhage (6 basic units)
20745	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
		F MANAGEMENT OF ANAESTHESIA for hernia repairs in upper abdomen, not being ch another item in this Subgroup applies (4 basic units)
20750	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35

T10 DE	LATIVE VALUE G	
		RE BENEFITS ARE
ONLY P	AYABLE FOR AN	AESTHESIA
ELIGIBI		6. UPPER ABDOMEN
		MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound
	dehiscence (6 basic	c units)
20752	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION OF N	MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic
	units)	
20754	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85
20754		MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic
	hernia (9 basic uni	· · · ·
20756	Fee: \$178.20	<b>Benefit:</b> 75% = \$133.65 85% = \$151.50
	INITIATION OF N	MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal
	blood vessels (15 b	vasic units)
20770	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45
_0//0		MANAGEMENT OF ANAESTHESIA for procedures within the peritoneal cavity in
		Eluding cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (8
	basic units)	
20790	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65
20170		anagement of anaesthesia for bariatric surgery in a patient with clinically severe
	obesity (10 basic u	
20791	(See para 118.8.29 of Fee: \$198.00	Explanatory notes to this Category) <b>Benefit:</b> $75\% = $148.50$ $85\% = $168.30$
		MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver
	biopsy) (13 basic u	
20792	<b>Fee:</b> \$257.40	<b>Benefit:</b> 75% = \$193.05 85% = \$218.80
20792		
	basic units)	MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15
20793	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45
		MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic
	units)	
20794	Fee: \$237.60	<b>Benefit:</b> 75% = \$178.20 85% = \$202.00
		MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the
	upper abdomen (10	) basic units)
20798	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-
		a the upper abdomen (6 basic units)
20700	Foot \$119 90	<b>Bonofit:</b> $75\% - \$\%0.10 - \$\%\% - \$101.00$
20799	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00

1. L(	JWER	ABDOME	N

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 7. Lower Abdomen		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units)	p	
20800	<b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)	2	
20802	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units)		
20803	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units)		
20804	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopic procedures (6 basic units)		
20805	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units)		
20806	<b>Fee:</b> \$138.60 <b>Benefit:</b> 75% = \$103.95 85% = \$117.85		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures ( basic units)	(4	
20810	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotrips urinary tract (6 basic units)		
20815	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units)		
20820	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not bein a service to which another item in this Subgroup applies (4 basic units)	ng	
20830	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35		

# 7. LOWER ABDOMEN

	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units)	
20832	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	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)	
20840	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	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)	
20841	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units)	
20842	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units)	
20844	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units)	
20845	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units)	
20846	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units)	
20847	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units)	
20848	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units)	
20850	<b>Fee:</b> \$237.60 <b>Benefit:</b> 75% = \$178.20 85% = \$202.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units)	
20855	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgrou applies (6 basic units)	
20860	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
20862	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units)	

7. LOWER ABDOMEN

	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units)
20863	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units)
20864	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units)
20866	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the
	lower abdomen	10 basic units)
20867	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION O (10 basic units)	F MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient)
20868	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal g a service to which another item in this subgroup applies (15 basic units)
20880	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units)
20882	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic
20884	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra- in the lower abdomen (6 basic units)
20886	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
ANAES ONLY F PERFO	AYABLE FOR A	ARE BENEFITS ARE
		tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service
		Subgroup 8. Perineum
20900		⁵ MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous neum not being a service to which another item in this Subgroup applies (3 basic units)
_0700		

	LE SERVICE	STATION WITH AN 8. PERINEUN	
	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50	
	INITIATION O and/or biopsy) (	F MANAGEMENT OF ANAESTHESIA for anorectal procedures (including endoscopy 4 basic units)	
20902	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
		F MANAGEMENT OF ANAESTHESIA for radical perineal procedures including prostatectomy or radical vulvectomy (7 basic units)	
20904	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85	
	involving the pe	F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery rineum (10 basic units)	
20905	(See para TN.10.2 <b>Fee:</b> \$198.00	28 of explanatory notes to this Category) <b>Benefit:</b> $75\% = $148.50$ $85\% = $168.30$	
20703		F MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units)	
20906	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
		F MANAGEMENT OF ANAESTHESIA for transurethral procedures (including py), not being a service to which another item in this Subgroup applies (4 basic units)	
20910	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
20911	including laser p	F MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery procedures (5 basic units) 29 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
		F MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder	
20912	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION O units)	F MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic	
20914	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85	
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7	
20916	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85	
	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units)		
20920	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units)		
20924	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
20926	INITIATION O	F MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (	

	basic units)	
	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units)	
20928	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units)	
20930	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units)	
20932	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units)	
20934	Fee: \$118.80         Benefit: 75% = \$89.10         85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units)	
20936	Fee: \$158.40         Benefit: 75% = \$118.80         85% = \$134.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units)	
20938	Fee: \$79.20         Benefit: 75% = \$59.40         85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units)	
20940	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units)	
20942	Fee: \$99.00         Benefit: 75% = \$74.25         85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units)	
20943	Fee: \$79.20         Benefit: 75% = \$59.40         85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units)	
20944	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units)	
20946	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65	
20948	INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal	

	of purse string li	gature (4 basic units)
	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units)
20950	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units)
20952	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for endometrial ablation or resection in hysteroscopy (5 basic units)
20953	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OI units)	F MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic
20954	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for evacuation of retained products of complication of confinement (4 basic units)
20956	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for or perineal tear following birth (5 basic units)
20958	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units)
20960		F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of
T10. RE ANAES ONLY P PERFO	post partum haen Fee: \$138.60 ELATIVE VALUE THESIA - MEDIC PAYABLE FOR A	F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units) Benefit: 75% = \$103.95 85% = \$117.85 GUIDE FOR ARE BENEFITS ARE
T10. RE ANAES ONLY P PERFO	post partum haen Fee: \$138.60 ELATIVE VALUE ( THESIA - MEDIC PAYABLE FOR A RMED IN ASSOC LE SERVICE Group T10. Rela	F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units) Benefit: 75% = \$103.95 85% = \$117.85 GUIDE FOR ARE BENEFITS ARE NAESTHESIA STATION WITH AN
T10. RE ANAES ONLY P PERFO	post partum haen Fee: \$138.60 ELATIVE VALUE ( THESIA - MEDIC PAYABLE FOR A RMED IN ASSOC LE SERVICE Group T10. Rela	F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units) Benefit: 75% = \$103.95 85% = \$117.85 GUIDE FOR ARE BENEFITS ARE NAESTHESIA SIATION WITH AN 9. PELVIS (EXCEPT HIP) ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY P PERFO	post partum haen Fee: \$138.60 ELATIVE VALUE ( THESIA - MEDIC PAYABLE FOR A RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe	F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units) Benefit: 75% = \$103.95 85% = \$117.85 GUIDE FOR ARE BENEFITS ARE NAESTHESIA CIATION WITH AN 9. PELVIS (EXCEPT HIP) ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
T10. RE ANAES ONLY P PERFO	post partum haen Fee: \$138.60 ELATIVE VALUE ( THESIA - MEDIC PAYABLE FOR A RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe	F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units) Benefit: 75% = \$103.95 85% = \$117.85 GUIDE FOR ARE BENEFITS ARE NAESTHESIA CIATION WITH AN 9. PELVIS (EXCEPT HIP) ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 9. Pelvis (Except Hip) F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous
T10. RE ANAES ONLY P PERFO ELIGIBI	post partum haen Fee: \$138.60 ELATIVE VALUE ( THESIA - MEDIC PAYABLE FOR A RMED IN ASSOC LE SERVICE Group T10. Rela Anaesthesia Pe INITIATION OI tissue of the ante Fee: \$59.40 INITIATION OI	F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units) Benefit: 75% = \$103.95 85% = \$117.85 GUIDE FOR ARE BENEFITS ARE NAESTHESIA CIATION WITH AN 9. PELVIS (EXCEPT HIP) ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service Subgroup 9. Pelvis (Except Hip) F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous erior pelvic region (anterior to iliac crest), except external genitalia (3 basic units)

ANAEST ONLY P	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA
	RMED IN ASSOCIATION WITH AN LE SERVICE 9. PELVIS (EXCEPT HIP)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the
	anterior iliac crest (4 basic units)
21112	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)
21114	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units)
21116	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units)
21120	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital (3 basic units)
21130	<b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units)
21140	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units)
21150	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units)
21155	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	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)
21160	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units)
21170	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65
ANAEST ONLY P PERFOR	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 10. UPPER LEG (EXCEPT KNEE)

10. UPPER LEG (EXCEPT KNEE)

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 10. Upper Leg (Except Knee)	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units)	
21195	<b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units)	
21199	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units)	
21200	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units)	
21202	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units)	
21210	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units)	
21212	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic units)	
21214	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic units)	
21216	<b>Fee:</b> \$277.20 <b>Benefit:</b> 75% = \$207.90 85% = \$235.65	
	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)	
21220	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	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)	
21230	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units)	
21232	<b>Fee:</b> \$99.00 <b>Benefit:</b> 75% = \$74.25 85% = \$84.15	

ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 10. UPPER LEG (EXCEPT KNEE)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units)
21234	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units)
21260	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units)
21270	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65
	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units)
21272	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units)
21274	(See para TN.10.24 of explanatory notes to this Category) <b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the upper leg (10 basic units)
21275	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> $$198.00$ <b>Benefit:</b> $75\% = $148.50$ $85\% = $168.30$
21273	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units)
21280	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR STHESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 11. KNEE AND POPLITEAL AREA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 11. Knee And Popliteal Area
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units)
21300	<b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units)
21321	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
21340	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur

ANAES ONLY F PERFO	PAYABLE FOR A RMED IN ASSO	CARE BENEFITS ARE NAESTHESIA CIATION WITH AN
ELIGIB		11. KNEE AND POPLITEAL AREA
	when performed	1 in the operating theatre of a hospital (4 basic units)
	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5
21360	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when e operating theatre of a hospital (3 basic units)
21380	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
	INITIATION C basic units)	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4
21382	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, atella when performed in the operating theatre of a hospital (3 basic units)
21390	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, atella (4 basic units)
21392	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a n another item in this Subgroup applies (4 basic units)
21400	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units)
21402	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85
		F MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units)
21403	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
21105		F MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units)
21404	<b>Fee:</b> \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
21404		<b>Denergy</b> $75\% = 574.23$ $85\% = 584.15$ <b>DF</b> MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair
		joint, undertaken in a hospital (3 basic units)
21420	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal a service to which another item in this Subgroup applies (4 basic units)
21430	<b>Fee:</b> \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or
21432		

11. KNEE AND POPLITEAL AREA

ELIGIB	LE SERVICE	11. KNEE AND POPLITEAL	AREA
	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or po	opliteal
	area, not being a	service to which another item in this Subgroup applies (8 basic units)	
21440	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surge	ry
	involving the kn	ee and/or popliteal area (10 basic units)	
	(See para TN.10.2	8 of explanatory notes to this Category)	
21445	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30	
	ELATIVE VALUE		
		ARE BENEFITS ARE	
	PAYABLE FOR A	IATION WITH AN	
	LE SERVICE	12. LOWER LEG (BELOW	KNEE)
	Group T10 Rel	ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For	
		rformed In Association With An Eligible Service	
		Subgroup 12. Lower Leg (Below Knee)	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutane	eous
		eg, ankle, or foot (3 basic units)	
21460	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tend	lons, or
		eg, ankle, or foot, not being a service to which another item in this Subgroup appl	lies (4
	basic units)		
21461	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
		F MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, and	de, or
	foot (3 basic uni	s)	
21462	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle join	nt (4
	basic units)		
21464	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
		F MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic u	nits)
		-	
21472	<b>Fee:</b> \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic ur	nits)
21474	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
		F MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower	
		cluding amputation, not being a service to which another item in this Subgroup a	pplies
21480	(4 basic units)		
_1.50			

12. LOWER LEG (BELOW KNEE)

	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower
	leg, ankle or foot	•
21482	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF (5 basic units)	F MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula
21484	<b>Fee:</b> \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units)
21486	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85
		F MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or n in a hospital (3 basic units)
21490	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg, graft, not being a service to which another item in this Subgroup applies (8 basic units)
21500	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic
21502	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not o which another item in this Subgroup applies (4 basic units)
21520	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units)	
21522	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF ankle or foot (15	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, basic units)
21530	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45
	INITIATION OF basic units)	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8
21532	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery ver leg (10 basic units)
21535	(See para TN.10.2 <b>Fee:</b> \$198.00	8 of explanatory notes to this Category) Benefit: $75\% = $148.50$ $85\% = $168.30$

13. SHOULDER AND AXILLA

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For	
		erformed In Association With An Eligible Service
		Subgroup 13. Shoulder And Axilla
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous oulder or axilla (3 basic units)
21600	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)	
21610	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	neck, sternoclav	F MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and vicular joint, acromioclavicular joint, or shoulder joint when performed in the operating bital (4 basic units)
21620	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	INITIATION O (5 basic units)	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint
21622	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units)	
21630	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units)	
21632	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units)
21634	Fee: \$178.20	<b>Benefit:</b> 75% = \$133.65 85% = \$151.50
	INITIATION O amputation (15	F MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) basic units)
21636	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75 85% = \$252.45
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units)
21638	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or a service to which another item in this Subgroup applies (8 basic units)
21650	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65
21652	INITIATION O	F MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm

13. SHOULDER AND AXILLA

	(10 basic units)		
	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units)		
21654	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units)		
21656	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units)		
21670	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35		
	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 hospita (3 basic units)		
21680	<b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital (4 basic units)		
21682	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units)		
21685	(See para TN.10.28 of explanatory notes to this Category)         Fee: \$198.00       Benefit: 75% = \$148.50       85% = \$168.30		
ANAES [.] ONLY P PERFOI	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN .E SERVICE 14. UPPER ARM AND ELBOV		
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 14. Upper Arm And Elbow		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units)		
	ussue of the upper ann of cloow (5 busic units)		
21700	Fee: \$59.40       Benefit: 75% = \$44.55       85% = \$50.50		

FLIGIR	LE SERVICE	14. UPPER ARM AND ELBOY
	Fee: \$79.20	Benefit: 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow
	(5 basic units)	
21712	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5
21714	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units)	
21716	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm performed in the operating theatre of a hospital (3 basic units)
21730	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4
21732	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35
		F MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or a service to which another item in this Subgroup applies (5 basic units)
21740	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION O elbow (6 basic u	F MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or nits)
21756	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units)
21760	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not o which another item in this Subgroup applies (8 basic units)
21770	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80 85% = \$134.65
	INITIATION OF (6 basic units)	F MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm
21772	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not o which another item in this Subgroup applies (4 basic units)

	LATIVE VALUE G THESIA - MEDICA	UIDE FOR RE BENEFITS ARE	
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	RMED IN ASSOCI	ATION WITH AN	14. UPPER ARM AND ELBOW
	(See para TN.10.28	of explanatory notes to this C	
	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50	
	INITIATION OF (15 basic units)	MANAGEMENT OF ANA	AESTHESIA for microsurgical reimplantation of upper arm
21790	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75	85% = \$252.45
ANAEST ONLY PA PERFOR	AYABLE FOR AN RMED IN ASSOCI E SERVICE	RE BENEFITS ARE AESTHESIA ATION WITH AN	15. FOREARM WRIST AND HAND
		formed In Association Wit	
		Subgroup	15. Forearm Wrist And Hand
		MANAGEMENT OF ANA rm, wrist or hand (3 basic u	AESTHESIA for procedures on the skin or subcutaneous units)
21800	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55	85% = \$50.50
		MANAGEMENT OF ANA bursae of the forearm, wri	AESTHESIA for procedures on the nerves, muscles, st or hand (4 basic units)
21810	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40	85% = \$67.35
			AESTHESIA for closed procedures on the radius, ulna, operating theatre of a hospital (3 basic units)
21820	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55	85% = \$50.50
			AESTHESIA for open procedures on the radius, ulna, wrist, nother item in this Subgroup applies (4 basic units)
21830	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40	85% = \$67.35
	INITIATION OF	MANAGEMENT OF ANA	AESTHESIA for total wrist replacement (7 basic units)
21832	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95	85% = \$117.85
	INITIATION OF (4 basic units)	MANAGEMENT OF ANA	AESTHESIA for arthroscopic procedures of the wrist joint
21834	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40	85% = \$67.35
			AESTHESIA for procedures on the arteries of forearm, wrist item in this Subgroup applies (8 basic units)
21840	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80	85% = \$134.65
	INITIATION OF hand (6 basic unit		AESTHESIA for embolectomy of artery of forearm, wrist or
21842	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10	85% = \$101.00

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

15. FOREARM WRIST AND HAND

	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)
21850	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	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)
21860	<b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units)
21865	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units)
21870	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (basic units)
21872	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65
ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN
ANAES ONLY P PERFO	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 16. ANAESTHESIA FOR BURN Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
ANAES ONLY P PERFO	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 16. ANAESTHESIA FOR BURN
ANAES ONLY P PERFO	THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 16. ANAESTHESIA FOR BURN Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
ANAES ONLY P PERFO	THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 16. Anaesthesia For Burns
ANAES ONLY P PERFO	THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 16. Anaesthesia For Burns         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
ANAES ONLY P PERFOI ELIGIBI	THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 16. Anaesthesia For Burns         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)         Fee: \$59.40       Benefit: 75% = \$44.55
ANAES ONLY P PERFOI ELIGIBI	THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         16. ANAESTHESIA FOR BURN         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 16. Anaesthesia For Burns         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)         Fee: \$59.40       Benefit: 75% = \$44.55       85% = \$50.50         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
ANAES ONLY P PERFOI ELIGIBI	THESIA - MEDICARE BENEFITS ARE         AYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 16. Anaesthesia For Burns         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)         Fee: \$59.40       Benefit: 75% = \$44.55       85% = \$50.50         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% of total body surface (3 basic units)         Fee: \$59.40       Benefit: 75% = \$44.55       85% = \$50.50         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)         Fee: \$99.00       Benefit: 75% = \$74.25       85% = \$84.15
ANAES ONLY P PERFOI ELIGIBI	THESIA - MEDICARE BENEFITS ARE         PAYABLE FOR ANAESTHESIA         RMED IN ASSOCIATION WITH AN         LE SERVICE         Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         Anaesthesia Performed In Association With An Eligible Service         Subgroup 16. Anaesthesia For Burns         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)         Fee: \$59.40       Benefit: 75% = \$44.55       85% = \$50.50         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)         Fee: \$99.00       Benefit: 75% = \$74.25       85% = \$84.15         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)         Fee: \$99.00       Benefit: 75% = \$74.25       85% = \$84.15         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

# 16. ANAESTHESIA FOR BURNS

	without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units)		
	<b>Fee:</b> \$178.20 <b>Benefit:</b> 75% = \$133.65 85% = \$151.50		
	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)		
21882	<b>Fee:</b> \$217.80 <b>Benefit:</b> 75% = \$163.35 85% = \$185.15		
	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)		
21883	<b>Fee:</b> \$257.40 <b>Benefit:</b> 75% = \$193.05 85% = \$218.80		
	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)		
21884	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units)		
21885	<b>Fee:</b> \$336.60 <b>Benefit:</b> 75% = \$252.45 85% = \$286.15		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units)		
21886	<b>Fee:</b> \$376.20 <b>Benefit:</b> 75% = \$282.15 85% = \$319.80		
	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)		
21887	<b>Fee:</b> \$415.80 <b>Benefit:</b> 75% = \$311.85 85% = \$353.45		
ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE PROCEDURES		
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 17. Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units)		
21900	<b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50		
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#### 17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

LEIOID		TROCEDORES	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units)		
21906	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION OF cervical (6 basic	MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: units)	
21908	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION OF posterior fossa (9	MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: basic units)	
21910	Fee: \$178.20	<b>Benefit:</b> 75% = \$133.65 85% = \$151.50	
	INITIATION OF lumbar or thoraci	MANAGEMENT OF ANAESTHESIA for injection procedure for discography: c (5 basic units)	
21912	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION OF cervical (6 basic	MANAGEMENT OF ANAESTHESIA for injection procedure for discography: units)	
21914	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units)	
21915	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units)		
21916	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION OF (5 basic units)	MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral	
21918	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units)		
21922	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units)		
21925	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for fluoroscopy (5 basic units)	
21926	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	INITIATION OF small bowel (5 ba	F MANAGEMENT OF ANAESTHESIA for barium enema or other opaque study of the asic units)	
21927	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
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#### 17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

	LE SERVICE	FROCEDORES
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units)
21930	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units)
21935	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time
	transoesophagea	l examination (6 basic units)
21936	(See para TN.10.2 <b>Fee:</b> \$118.80	6 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$89.10 85% = \$101.00
21930		F MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic
	units)	
21939	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50
		F MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary
	arteriography, ve pacemaker (7 ba	entriculography, cardiac mapping, insertion of automatic defibrillator or transvenous sic units)
	-	
21941	<b>Fee:</b> \$138.60	5 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$103.95 85% = \$117.85
		F MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures
	including radio f	requency ablation (10 basic units)
21942	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
		F MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of on catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure
21943	<b>Fee:</b> \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
		F MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or
	epidural injection	n (5 basic units)
21945	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpos of transplantation (5 basic units)	
21949	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for muscle biopsy for malignant hyperpyrexia (10 basic units)	
21952	Fee: \$198.00	<b>Benefit:</b> 75% = \$148.50 85% = \$168.30
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)
21955	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15
21959	INITIATION O	F MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5

#### 17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

	basic units)		
	,		
	<b>Fee:</b> \$99.00	<b>Benefit:</b> 75% = \$74.25	
		tympanic membrane insertion	AESTHESIA for electrocochleography by extratympanic on method (5 basic units)
21962	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25	85% = \$84.15
		at there is a clinical need for	<b>VAESTHESIA</b> as a therapeutic procedure where it can be r anaesthesia, not for the treatment of headache of any
21965	(See para TN.10.) <b>Fee:</b> \$99.00	11 of explanatory notes to this <b>Benefit:</b> 75% = \$74.25	
			VAESTHESIA during hyperbaric therapy where the medical (including the administration of oxygen) (8 basic units)
21969	Fee: \$158.40	<b>Benefit:</b> 75% = \$118.80	0 85% = \$134.65
			AESTHESIA during hyperbaric therapy where the medical uding the administration of oxygen) (15 basic units)
21970	Fee: \$297.00	<b>Benefit:</b> 75% = \$222.75	5 85% = \$252.45
	INITIATION O sources (5 basic		IAESTHESIA for brachytherapy using radioactive sealed
21973	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25	85% = \$84.15
	INITIATION O units)	F MANAGEMENT OF AN	IAESTHESIA for therapeutic nuclear medicine (5 basic
21976	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25	85% = \$84.15
	INITIATION O	F MANAGEMENT OF AN	AESTHESIA for radiotherapy (5 basic units)
21980	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25	85% = \$84.15
	history of prior		TING, using skin sensitivity methods in a patient with a id reaction or cardiovascular collapse associated with the units)
21981	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40	85% = \$67.35
ANAES ONLY F PERFO	AYABLE FOR A	ARE BENEFITS ARE	18. MISCELLANEOU
		ative Value Guide For Ana erformed In Association W	esthesia - Medicare Benefits Are Only Payable For ith An Eligible Service
		Sub	group 18. Miscellaneous
,	1		

T10 RF	LATIVE VALUE GUIDE FOR
ANAES	THESIA - MEDICARE BENEFITS ARE
	PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN
	LE SERVICE 18. MISCELLANEOUS
	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units)
	(See para TN.10.12 of explanatory notes to this Category)
21990	Fee:         \$59.40         Benefit:         75% = \$44.55         85% = \$50.50
	INITIATION OF MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units)
21992	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	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)
21997	(See para TN.10.13 of explanatory notes to this Category)           Fee: \$79.20         Benefit: 75% = \$59.40         85% = \$67.35
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 19. Therapeutic And Diagnostic Services
	COLLECTION OF BLOOD FOR AUTOLOGOUS TRANSFUSION or when homologous blood is required for immediate transfusion in an emergency situation, when performed in association with the administration of anaesthesia (3 basic units)
22001	(See para TN.10.8 of explanatory notes to this Category)Fee: $$59.40$ Benefit: $75\% = $44.55$ $85\% = $50.50$
	ADMINISTRATION OF BLOOD or bone marrow already collected when performed in association with the administration of anaesthesia (4 basic units)
22002	(See para TN.10.8 of explanatory notes to this Category)Fee: $\$79.20$ Benefit: $75\% = \$59.40$ $85\% = \$67.35$
	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)
22007	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units)
22008	<b>Fee:</b> \$79.20 <b>Benefit:</b> 75% = \$59.40 85% = \$67.35
	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
22012	maximum of 4 pressures (not being a service to which item 13876 applies) when performed in

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

ELIGIBL	LE SERVICE	19. THER	RAPEUTIC AND DIAGNOSTIC SERVICES
		e administration of anaesthesia (3 basic	e units)
	<b>Fee:</b> \$59.40	explanatory notes to this Category) Benefit: $75\% = $44.55$ $85\% = $50.50$	)
	intracavity), by ind maximum of 4 pres	welling catheter - once only for each ty ssures (not being a service to which iter	almonary arterial, systemic arterial or cardiac ype of pressure on any calendar day, up to a m 13876 applies) when performed in g to another discrete operation on the same day
22014	(See para TN.10.8 of <b>Fee:</b> \$59.40	explanatory notes to this Category) <b>Benefit:</b> 75% = \$44.55 85% = \$50.50	)
			ncluding pulmonary wedge pressure and on with the administration of anaesthesia (6
22015	(See para TN.10.8 of <b>Fee:</b> \$118.80	explanatory notes to this Category) <b>Benefit:</b> 75% = \$89.10 85% = \$101.0	00
	RESPIRATORY S concentrations in in analysis and a writ	nspired or expired air, alveolar gas or b ten record of the results, when perform	XCHANGE FUNCTION OF THE neters, including pressures, volumes, flow, gas blood and incorporating serial arterial blood gas ed in association with the administration of to which item 11503 applies (7 basic units)
22018	Fee: \$138.60	<b>Benefit:</b> 75% = \$103.95 85% = \$117	.85
			s or open exposure, not being a service to with the administration of anaesthesia (4 basic
22020	(See para TN.1.6, TN <b>Fee:</b> \$79.20	1.10.8 of explanatory notes to this Category <b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	INTRAARTERIAL CANNULATION when performed in association with the administration of anaesthesia (4 basic units)		n association with the administration of
22025	(See para TN.10.8 of <b>Fee:</b> \$79.20	explanatory notes to this Category) Benefit: 75% = \$59.40 85% = \$67.35	5
	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)		
22031	(See para 11.10.19 ( Fee: \$99.00	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$74.25 85% = \$84.15	5
	using an in-situ cat	heter, in association with anaesthesia a	nt) of a therapeutic substance or substances, and surgery, for postoperative pain e to which 22031 applies (3 basic units)
22036	(See para TN.10.20 c <b>Fee:</b> \$59.40	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$44.55 85% = \$50.50	)

**19. THERAPEUTIC AND DIAGNOSTIC SERVICES** 

	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room theatre or recovery room for the control of post operative pain via the femoral OR sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (2 basic units)
22040	(See para TN.10.17, TN.10.21 of explanatory notes to this Category) <b>Fee:</b> \$39.60 <b>Benefit:</b> 75% = \$29.70 85% = \$33.70
	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral AND sciatic nerves, in conjunction with hip, knee, ankle or foot surgery (3 basic units)
22045	(See para TN.10.17, TN.10.21 of explanatory notes to this Category)         Fee: \$59.40       Benefit: 75% = \$44.55       85% = \$50.50
	INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus in conjunction with shoulder surgery (2 basic units)
22050	(See para TN.10.17, TN.10.21 of explanatory notes to this Category) <b>Fee:</b> \$39.60 <b>Benefit:</b> 75% = \$29.70 85% = \$33.70
	INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units)
22051	<b>Fee:</b> \$178.20 <b>Benefit:</b> 75% = \$133.65 85% = \$151.50
	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)
22055	(See para TN.10.10 of explanatory notes to this Category) <b>Fee:</b> \$237.60 <b>Benefit:</b> 75% = \$178.20 85% = \$202.00
	WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (20 basic units)
22060	(See para TN.10.10 of explanatory notes to this Category) <b>Fee:</b> \$396.00 <b>Benefit:</b> 75% = \$297.00 85% = \$336.60
	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)
22065	(See para TN.10.10 of explanatory notes to this Category)           Fee: \$99.00         Benefit: 75% = \$74.25         85% = \$84.15
	CARDIOPLEGIA, blood or crystalloid, administration by any route, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (10 basic units)
22070	(See para TN.10.10 of explanatory notes to this Category)         Fee: \$198.00       Benefit: 75% = \$148.50       85% = \$168.30
22075	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with

ANAEST ONLY PA PERFOR	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE YABLE FOR ANAESTHESIA MED IN ASSOCIATION WITH AN	
ELIGIBLE	SERVICE	19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	anaesthesia to which an item in Subgroup 21 a	
	(See para TN.10.10 of explanatory notes to this Cat <b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75	egory) 85% = \$252.45
ANAEST ONLY PA PERFOR	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE YABLE FOR ANAESTHESIA MED IN ASSOCIATION WITH AN E SERVICE	20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE
	Group T10. Relative Value Guide For Anaes Anaesthesia Performed In Association With	thesia - Medicare Benefits Are Only Payable For An Eligible Service
	Subgroup 20. Administration Of A	naesthesia In Connection With A Dental Service
		EDICAL PRACTITIONER OF ANAESTHESIA for ision of soft tissue or removal of bone (6 basic units)
22900	(See para TN.10.14 of explanatory notes to this Cat <b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 8	
	INITIATION OF MANAGEMENT OF ANA	ESTHESIA for restorative dental work (6 basic units)
22905	(See para TN.10.14 of explanatory notes to this Cat <b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 8	
ANAESTI ONLY PA PERFOR	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE YABLE FOR ANAESTHESIA MED IN ASSOCIATION WITH AN SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	Group T10. Relative Value Guide For Anaes Anaesthesia Performed In Association With	thesia - Medicare Benefits Are Only Payable For An Eligible Service
	Subgroup 21. Ar	aesthesia/Perfusion Time Units
	ANAESTHESIA, PERFUSION OR ASSISTA	NCE AT ANAESTHESIA
	(a) administration of anaesthesia performed in 22900 to 22905; or	association with an item in the range 20100 to 21997 or
	(b) perfusion performed in association with ite	m 22060; or
	(c) for assistance at anaesthesia performed in a	association with items 25200 to 25205
23010	For a period of:	

21. ANAESTHESIA/PERFUSION TIME UNITS

	(FIFTEEN MINUTES OR LESS) (1 basic units)		
	(See para TN.10.3 <b>Fee:</b> \$19.80	of explanatory notes to this Category) Benefit: 75% = \$14.85 85% = \$16.85	
	16 MINUTES T	O 20 MINUTES (2 basic units)	
23021	Fee: \$39.60	<b>Benefit:</b> 75% = \$29.70 85% = \$33.70	
	21 MINUTES T	O 25 MINUTES (2 basic units)	
23022	Fee: \$39.60	<b>Benefit:</b> 75% = \$29.70 85% = \$33.70	
	26 MINUTES T	O 30 MINUTES (2 basic units)	
23023	Fee: \$39.60	<b>Benefit:</b> 75% = \$29.70 85% = \$33.70	
	31 MINUTES T	O 35 MINUTES (3 basic units)	
23031	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50	
	36 MINUTES T	O 40 MINUTES (3 basic units)	
23032	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50	
	41 MINUTES T	O 45 MINUTES (3 basic units)	
23033	Fee: \$59.40	<b>Benefit:</b> 75% = \$44.55 85% = \$50.50	
	46 MINUTES T	O 50 MINUTES (4 basic units)	
23041	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	51 MINUTES T	O 55 MINUTES (4 basic units)	
23042	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	56 MINUTES T	O 1:00 HOUR (4 basic units)	
23043	Fee: \$79.20	<b>Benefit:</b> 75% = \$59.40 85% = \$67.35	
	1:01 HOURS TO	D 1:05 HOURS (5 basic units)	
23051	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	1:06 HOURS TO	D 1:10 HOURS (5 basic units)	
23052	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	1:11 HOURS TO	D 1:15 HOURS (5 basic units)	
23053	Fee: \$99.00	<b>Benefit:</b> 75% = \$74.25 85% = \$84.15	
	1:16 HOURS TO	D 1:20 HOURS (6 basic units)	
23061	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00	
	1:21 HOURS TO	D 1:25 HOURS (6 basic units)	
23062	Fee: \$118.80	<b>Benefit:</b> 75% = \$89.10 85% = \$101.00	

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN				
	E SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS			
	1:26 HOURS TO 1:30 HOURS (6 basic units)			
23063	<b>Fee:</b> \$118.80 <b>Benefit:</b> 75% = \$89.10 85% = \$101.00			
	1:31 HOURS TO 1:35 HOURS (7 basic units)			
23071	<b>Fee:</b> \$138.60 <b>Benefit:</b> 75% = \$103.95 85% = \$117.85			
	1:36 HOURS TO 1:40 HOURS (7 basic units)			
23072	<b>Fee:</b> \$138.60 <b>Benefit:</b> 75% = \$103.95 85% = \$117.85			
	1:41 HOURS TO 1:45 HOURS (7 basic units)			
23073	<b>Fee:</b> \$138.60 <b>Benefit:</b> 75% = \$103.95 85% = \$117.85			
	1:46 HOURS TO 1:50 HOURS (8 basic units)			
23081	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65			
	1:51 HOURS TO 1:55 HOURS (8 basic units)			
23082	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65			
	1:56 HOURS TO 2:00 HOURS (8 basic units)			
23083	<b>Fee:</b> \$158.40 <b>Benefit:</b> 75% = \$118.80 85% = \$134.65			
	2:01 HOURS TO 2:10 HOURS (9 basic units)			
23091	<b>Fee:</b> \$178.20 <b>Benefit:</b> 75% = \$133.65 85% = \$151.50			
	2:11 HOURS TO 2:20 HOURS (10 basic units)			
23101	<b>Fee:</b> \$198.00 <b>Benefit:</b> 75% = \$148.50 85% = \$168.30			
	2:21 HOURS TO 2:30 HOURS (11 basic units)			
23111	<b>Fee:</b> \$217.80 <b>Benefit:</b> 75% = \$163.35 85% = \$185.15			
	2:31 HOURS TO 2:40 HOURS (12 basic units)			
23112	<b>Fee:</b> \$237.60 <b>Benefit:</b> 75% = \$178.20 85% = \$202.00			
	2:41 HOURS TO 2:50 HOURS (13 basic units)			
23113	<b>Fee:</b> \$257.40 <b>Benefit:</b> 75% = \$193.05 85% = \$218.80			
	2:51 HOURS TO 3:00 HOURS (14 basic units)			
23114	<b>Fee:</b> \$277.20 <b>Benefit:</b> 75% = \$207.90 85% = \$235.65			
	3:01 HOURS TO 3:10 HOURS (15 basic units)			
23115	<b>Fee:</b> \$297.00 <b>Benefit:</b> 75% = \$222.75 85% = \$252.45			
	3:11 HOURS TO 3:20 HOURS (16 basic units)			
23116	<b>Fee:</b> \$316.80 <b>Benefit:</b> 75% = \$237.60 85% = \$269.30			

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA					
PERFO		IATION WITH AN	21. ANAESTHESIA/PERFUSION TIME UNITS		
	3:21 HOURS TO	O 3:30 HOURS (17 basic unit	ts)		
23117	Fee: \$336.60	<b>Benefit:</b> 75% = \$252.45	85% = \$286.15		
-	3:31 HOURS TO	O 3:40 HOURS (18 basic uni	ts)		
23118	Fee: \$356.40	<b>Benefit:</b> 75% = \$267.30	85% = \$302.95		
	3:41 HOURS TO	O 3:50 HOURS (19 basic uni	ts)		
23119	Fee: \$376.20	<b>Benefit:</b> 75% = \$282.15	85% = \$319.80		
	3:51 HOURS TO	0 4:00 HOURS (20 basic uni	ts)		
23121	Fee: \$396.00	<b>Benefit:</b> 75% = \$297.00	85% = \$336.60		
		0 4:10 HOURS (21 basic uni	· · · · · · · · · · · · · · · · · · ·		
23170	Fee: \$415.80	<b>Benefit:</b> 75% = \$311.85	85% = \$353.45		
	4:11 HOURS TO	0 4:20 HOURS (22 basic uni	ts)		
23180	<b>Fee:</b> \$435.60	<b>Benefit:</b> 75% = \$326.70	85% = \$370.30		
		0 4:30 HOURS (23 basic unit			
23190	<b>Fee:</b> \$455.40	<b>Benefit:</b> 75% = \$341.55	85% = \$387.10		
23170		0 4:40 HOURS (24 basic unit			
23200	Fee: \$475.20	<b>Benefit:</b> 75% = \$356.40	85% - \$403.95		
23200		0 4:50 HOURS (25 basic unit			
23210	Fee: \$495.00	<b>Benefit:</b> 75% = \$371.25			
25210	2 000 0 1000	5:00 HOURS (26 basic unit			
23220	Fee: \$514.80	<b>Benefit:</b> 75% = \$386.10			
23220		0 5:10 HOURS (27 basic unit			
22220	<b>Fee:</b> \$534.60	<b>Benefit:</b> 75% = \$400.95			
23230		5:20  HOURS (28  basic unit)			
222.40		,			
23240	<b>Fee:</b> \$554.40	<b>Benefit:</b> 75% = \$415.80 D 5:30 HOURS (29 basic unit			
22250					
23250	<b>Fee:</b> \$574.20	<b>Benefit:</b> 75% = \$430.65 D 5:40 HOURS (30 basic unit			
		, ,	, ,		
23260	Fee: \$594.00	<b>Benefit:</b> 75% = \$445.50			
	5:41 HOURS TO 5:50 HOURS (31 basic units)				
23270	Fee: \$613.80	<b>Benefit:</b> 75% = \$460.35	85% = \$532.10		

T10. REL	ATIVE VALUE GUIDE FOR	
-	HESIA - MEDICARE BENEFITS ARE	
	MED IN ASSOCIATION WITH AN	
ELIGIBLE	E SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	(5:51 HOURS TO 6:00 HOURS (32 basic units)	
23280	<b>Fee:</b> \$633.60 <b>Benefit:</b> 75% = \$475.20 85	5% = \$551.90
	6:01 HOURS TO 6:10 HOURS (33 basic units)	
23290	<b>Fee:</b> \$653.40 <b>Benefit:</b> 75% = \$490.05 85	5% = \$571.70
	6:11 HOURS TO 6:20 HOURS (34 basic units)	
23300	<b>Fee:</b> \$673.20 <b>Benefit:</b> 75% = \$504.90 85	5% = \$591.50
	6:21 HOURS TO 6:30 HOURS (35 basic units)	
23310	<b>Fee:</b> \$693.00 <b>Benefit:</b> 75% = \$519.75 85	5% = \$611.30
	6:31 HOURS TO 6:40 HOURS (36 basic units)	
23320	<b>Fee:</b> \$712.80 <b>Benefit:</b> 75% = \$534.60 85	5% = \$631.10
	6:41 HOURS TO 6:50 HOURS (37 basic units)	
23330	<b>Fee:</b> \$732.60 <b>Benefit:</b> 75% = \$549.45 85	5% = \$650.90
20000	6:51 HOURS TO 7:00 HOURS (38 basic units)	
23340	<b>Fee:</b> \$752.40 <b>Benefit:</b> 75% = \$564.30 85	5% = \$670.70
20010	7:01 HOURS TO 7:10 HOURS (39 basic units)	
23350	<b>Fee:</b> \$772.20 <b>Benefit:</b> 75% = \$579.15 85	5% - \$690.50
20000	7:11 HOURS TO 7:20 HOURS (40 basic units)	
23360	<b>Fee:</b> \$792.00 <b>Benefit:</b> 75% = \$594.00 85	5% - \$710.30
23300	7:21 HOURS TO 7:30 HOURS (41 basic units)	/// - \$/10.50
23370	<b>Fee:</b> \$811.80 <b>Benefit:</b> 75% = \$608.85 85	60' =  \$720.10
23370	7:31 HOURS TO 7:40 HOURS (42 basic units)	% = \$750.10
22200	``````````````````````````````````````	(n) († 740.00
23380	Fee: \$831.60         Benefit: 75% = \$623.70         85           7:41 HOURS TO 7:50 HOURS (43 basic units)	% = \$749.90
••••		
23390	Fee: \$851.40         Benefit: 75% = \$638.55         85           7:51 HOURS TO 8:00 HOURS (44 basic units)	% = \$/69.70
23400	Fee:         \$871.20         Benefit:         75% = \$653.40         85           2.01         HOUDS TO 2.10         HOUDS (45 hours)         10	5% = \$789.50
	8:01 HOURS TO 8:10 HOURS (45 basic units)	
23410	<b>Fee:</b> \$891.00 <b>Benefit:</b> 75% = \$668.25 85	5% = \$809.30
	8:11 HOURS TO 8:20 HOURS (46 basic units)	
23420	<b>Fee:</b> \$910.80 <b>Benefit:</b> 75% = \$683.10 85	5% = \$829.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN		
		21. ANAESTHESIA/PERFUSION TIME UNITS
	8:21 HOURS TO 8:30 HOURS (47 basic unit	ts)
23430	<b>Fee:</b> \$930.60 <b>Benefit:</b> 75% = \$697.95	85% = \$848.90
	8:31 HOURS TO 8:40 HOURS (48 basic unit	ts)
23440	<b>Fee:</b> \$950.40 <b>Benefit:</b> 75% = \$712.80	85% = \$868.70
	8:41 HOURS TO 8:50 HOURS (49 basic unit	ts)
23450	<b>Fee:</b> \$970.20 <b>Benefit:</b> 75% = \$727.65	85% = \$888.50
-	8:51 HOURS TO 9:00 HOURS (50 basic unit	ts)
23460	<b>Fee:</b> \$990.00 <b>Benefit:</b> 75% = \$742.50	85% = \$908.30
	9:01 HOURS TO 9:10 HOURS (51 basic unit	
23470	<b>Fee:</b> \$1,009.80 <b>Benefit:</b> 75% = \$757.35	85% = \$928.10
	9:11 HOURS TO 9:20 HOURS (52 basic unit	ts)
23480	<b>Fee:</b> \$1,029.60 <b>Benefit:</b> 75% = \$772.20	85% = \$947.90
	9:21 HOURS TO 9:30 HOURS (53 basic unit	ts)
23490	<b>Fee:</b> \$1,049.40 <b>Benefit:</b> 75% = \$787.05	85% = \$967.70
	9:31 HOURS TO 9:40 HOURS (54 basic unit	ts)
23500	<b>Fee:</b> \$1,069.20 <b>Benefit:</b> 75% = \$801.90	85% = \$987.50
	9:41 HOURS TO 9:50 HOURS (55 basic unit	
23510	<b>Fee:</b> \$1,089.00 <b>Benefit:</b> 75% = \$816.75	85% = \$1007.30
	9:51 HOURS TO 10:00 HOURS (56 basic un	
23520	<b>Fee:</b> \$1,108.80 <b>Benefit:</b> 75% = \$831.60	85% = \$1027.10
	10:01 HOURS TO 10:10 HOURS (57 basic u	
23530	<b>Fee:</b> \$1,128.60 <b>Benefit:</b> 75% = \$846.45	85% = \$1046.90
	10:11 HOURS TO 10:20 HOURS (58 basic u	
23540	<b>Fee:</b> \$1,148.40 <b>Benefit:</b> 75% = \$861.30	85% = \$1066.70
20070	10:21 HOURS TO 10:30 HOURS (59 basic u	
23550	<b>Fee:</b> \$1,168.20 <b>Benefit:</b> 75% = \$876.15	
23330	10:31 HOURS TO 10:40 HOURS (60 basic u	
22560		, ,
23560	Fee: \$1,188.00         Benefit: 75% = \$891.00           10:41 HOURS TO 10:50 HOURS (61 basic u	
22570		, ,
23570	<b>Fee:</b> \$1,207.80 <b>Benefit:</b> 75% = \$905.85	85% = \$1126.10

T10. RE	LATIVE VALUE GUIDE FOR
ANAES	THESIA - MEDICARE BENEFITS ARE
-	PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN
	LE SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS
	10:51 HOURS TO 11:00 HOURS (62 basic units)
23580	<b>Fee:</b> \$1,227.60 <b>Benefit:</b> 75% = \$920.70 85% = \$1145.90
	11:01 HOURS TO 11:10 HOURS (63 basic units)
23590	<b>Fee:</b> \$1,247.40 <b>Benefit:</b> 75% = \$935.55 85% = \$1165.70
23370	11:11 HOURS TO 11:20 HOURS (64 basic units)
23600	<b>Fee:</b> \$1,267.20 <b>Benefit:</b> 75% = \$950.40 85% = \$1185.50
23000	11:21 HOURS TO 11:30 HOURS (65 basic units)
23610	Fee:         \$1,287.00         Benefit:         75% = \$965.25         85% = \$1205.30           11:21         HOLDS TO 11:40         HOLDS (66 basic units)
	11:31 HOURS TO 11:40 HOURS (66 basic units)
23620	Fee: \$1,306.80         Benefit: 75% = \$980.10         85% = \$1225.10
	11:41 HOURS TO 11:50 HOURS (67 basic units)
23630	Fee: \$1,326.60         Benefit: 75% = \$994.95         85% = \$1244.90
	11:51 HOURS TO 12:00 HOURS (68 basic units)
23640	<b>Fee:</b> \$1,346.40 <b>Benefit:</b> 75% = \$1009.80 85% = \$1264.70
	12:01 HOURS TO 12:10 HOURS (69 basic units)
23650	<b>Fee:</b> \$1,366.20 <b>Benefit:</b> 75% = \$1024.65 85% = \$1284.50
	12:11 HOURS TO 12:20 HOURS (70 basic units)
23660	<b>Fee:</b> \$1,386.00 <b>Benefit:</b> 75% = \$1039.50 85% = \$1304.30
	12:21 HOURS TO 12:30 HOURS (71 basic units)
23670	<b>Fee:</b> \$1,405.80 <b>Benefit:</b> 75% = \$1054.35 85% = \$1324.10
23070	12:31 HOURS TO 12:40 HOURS (72 basic units)
23680	<b>Fee:</b> \$1,425.60 <b>Benefit:</b> 75% = \$1069.20 85% = \$1343.90
23080	12:41 HOURS TO 12:50 HOURS (73 basic units)
22600	
23690	Fee: \$1,445.40         Benefit: 75% = \$1084.05         85% = \$1363.70           12:51 HOURS TO 13:00 HOURS (74 basic units)
23700	Fee:         \$1,465.20         Benefit:         75% = \$1098.90         85% = \$1383.50           12.01         HOUDES TO 12.10         HOUDES (75.1)         HOUDES (75.1)         HOUDES (75.1)
	13:01 HOURS TO 13:10 HOURS (75 basic units)
23710	Fee: \$1,485.00         Benefit: 75% = \$1113.75         85% = \$1403.30
	13:11 HOURS TO 13:20 HOURS (76 basic units)
23720	<b>Fee:</b> \$1,504.80 <b>Benefit:</b> 75% = \$1128.60 85% = \$1423.10

	ATIVE VALUE GUIDE FOR
	HESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA
PERFOR	MED IN ASSOCIATION WITH AN
ELIGIBL	E SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS
	13:21 HOURS TO 13:30 HOURS (77 basic units)
23730	Fee: \$1,524.60         Benefit: 75% = \$1143.45         85% = \$1442.90
	13:31 HOURS TO 13:40 HOURS (78 basic units)
23740	<b>Fee:</b> \$1,544.40 <b>Benefit:</b> 75% = \$1158.30 85% = \$1462.70
	13:41 HOURS TO 13:50 HOURS (79 basic units)
23750	<b>Fee:</b> \$1,564.20 <b>Benefit:</b> 75% = \$1173.15 85% = \$1482.50
	13:51 HOURS TO 14:00 HOURS (80 basic units)
23760	<b>Fee:</b> \$1,584.00 <b>Benefit:</b> 75% = \$1188.00 85% = \$1502.30
20100	14:01 HOURS TO 14:10 HOURS (81 basic units)
23770	<b>Fee:</b> \$1,603.80 <b>Benefit:</b> 75% = \$1202.85 85% = \$1522.10
23770	14:11 HOURS TO 14:20 HOURS (82 basic units)
22500	
23780	Fee: \$1,623.60         Benefit: 75% = \$1217.70         85% = \$1541.90           14:21 HOURS TO 14:30 HOURS (83 basic units)
23790	Fee:         \$1,643.40         Benefit:         75% = \$1232.55         85% = \$1561.70
	14:31 HOURS TO 14:40 HOURS (84 basic units)
23800	Fee: \$1,663.20         Benefit: 75% = \$1247.40         85% = \$1581.50
	14:41 HOURS TO 14:50 HOURS (85 basic units)
23810	<b>Fee:</b> \$1,683.00 <b>Benefit:</b> 75% = \$1262.25 85% = \$1601.30
	14:51 HOURS TO 15:00 HOURS (86 basic units)
23820	<b>Fee:</b> \$1,702.80 <b>Benefit:</b> 75% = \$1277.10 85% = \$1621.10
	15:01 HOURS TO 15:10 HOURS (87 basic units)
23830	<b>Fee:</b> \$1,722.60 <b>Benefit:</b> 75% = \$1291.95 85% = \$1640.90
	15:11 HOURS TO 15:20 HOURS (88 basic units)
23840	<b>Fee:</b> \$1,742.40 <b>Benefit:</b> 75% = \$1306.80 85% = \$1660.70
23040	15:21 HOURS TO 15:30 HOURS (89 basic units)
22850	
23850	Fee: \$1,762.20         Benefit: 75% = \$1321.65         85% = \$1680.50           15:31 HOURS TO 15:40 HOURS (90 basic units)
23860	Fee:         \$1,782.00         Benefit:         75% = \$1336.50         85% = \$1700.30           15:41 HOURS TO 15:50 HOURS (01 basis prits)
	15:41 HOURS TO 15:50 HOURS (91 basic units)
23870	Fee: \$1,801.80         Benefit: 75% = \$1351.35         85% = \$1720.10

T10. REI	LATIVE VALUE GUIDE FOR	
-	THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA	
PERFOR	MED IN ASSOCIATION WITH AN	
ELIGIBL		21. ANAESTHESIA/PERFUSION TIME UNITS
	15:51 HOURS TO 16:00 HOURS (92 basic units)	
23880	<b>Fee:</b> \$1,821.60 <b>Benefit:</b> 75% = \$1366.20 85% =	= \$1739.90
	16:01 HOURS TO 16:10 HOURS (93 basic units)	
23890	Fee: \$1,841.40 Benefit: 75% = \$1381.05 85% =	= \$1759.70
	16:11 HOURS TO 16:20 HOURS (94 basic units)	
23900	<b>Fee:</b> \$1,861.20 <b>Benefit:</b> 75% = \$1395.90 85% =	= \$1779.50
	16:21 HOURS TO 16:30 HOURS (95 basic units)	
23910	<b>Fee:</b> \$1,881.00 <b>Benefit:</b> 75% = \$1410.75 85% =	= \$1799.30
	16:31 HOURS TO 16:40 HOURS (96 basic units)	
23920	<b>Fee:</b> \$1,900.80 <b>Benefit:</b> 75% = \$1425.60 85% =	= \$1819.10
	16:41 HOURS TO 16:50 HOURS (97 basic units)	
23930	<b>Fee:</b> \$1,920.60 <b>Benefit:</b> 75% = \$1440.45 85% =	- \$1838.90
23730	16:51 HOURS TO 17:00 HOURS (98 basic units)	- 41050.70
23940	<b>Fee:</b> \$1,940.40 <b>Benefit:</b> 75% = \$1455.30 85% =	- \$1858.70
23940	17:01 HOURS TO 17:10 HOURS (99 basic units)	- \$1030.70
22050		¢1070.50
23950	Fee: \$1,960.20         Benefit: 75% = \$1470.15         85% =           17:11 HOURS TO 17:20 HOURS (100 basic units)	= \$18/8.50
23960	Fee:         \$1,980.00         Benefit:         75% = \$1485.00         85% =           17.21         101105         72.20         101105         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101         101	= \$1898.30
	17:21 HOURS TO 17:30 HOURS (101 basic units)	
23970	<b>Fee:</b> \$1,999.80 <b>Benefit:</b> 75% = \$1499.85 85% =	= \$1918.10
	17:31 HOURS TO 17:40 HOURS (102 basic units)	
23980	<b>Fee:</b> \$2,019.60 <b>Benefit:</b> 75% = \$1514.70 85% =	= \$1937.90
	17:41 HOURS TO 17:50 HOURS (103 basic units)	
23990	<b>Fee:</b> \$2,039.40 <b>Benefit:</b> 75% = \$1529.55 85% =	= \$1957.70
	17:51 HOURS TO 18:00 HOURS (104 basic units)	
24100	Fee: \$2,059.20 Benefit: 75% = \$1544.40 85% =	= \$1977.50
	18:01 HOURS TO 18:10 HOURS (105 basic units)	
24101	Fee: \$2,079.00 Benefit: 75% = \$1559.25 85% =	= \$1997.30
	18:11 HOURS TO 18:20 HOURS (106 basic units)	
24102	Fee: \$2,098.80 Benefit: 75% = \$1574.10 85% =	= \$2017.10
- 1102		<i>4=01.110</i>

T10. RE	LATIVE VALUE GUIDE FOR	
_	THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA	
PERFOR	RMED IN ASSOCIATION WITH AN	
ELIGIBL		21. ANAESTHESIA/PERFUSION TIME UNITS
	18:21 HOURS TO 18:30 HOURS (107 basic units)	
24103	<b>Fee:</b> \$2,118.60 <b>Benefit:</b> 75% = \$1588.95 85% =	= \$2036.90
	18:31 HOURS TO 18:40 HOURS (108 basic units)	
24104	<b>Fee:</b> \$2,138.40 <b>Benefit:</b> 75% = \$1603.80 85% =	= \$2056.70
	18:41 HOURS TO 18:50 HOURS (109 basic units)	
24105	<b>Fee:</b> \$2,158.20 <b>Benefit:</b> 75% = \$1618.65 85% =	= \$2076.50
	18:51 HOURS TO 19:00 HOURS (110 basic units)	
24106	<b>Fee:</b> \$2,178.00 <b>Benefit:</b> 75% = \$1633.50 85% =	= \$2096.30
	19:01 HOURS TO 19:10 HOURS (111 basic units)	
24107	<b>Fee:</b> \$2,197.80 <b>Benefit:</b> 75% = \$1648.35 85% =	= \$2116.10
	19:11 HOURS TO 19:20 HOURS (112 basic units)	
24108	<b>Fee:</b> \$2,217.60 <b>Benefit:</b> 75% = \$1663.20 85% =	= \$2135.90
21100	19:21 HOURS TO 19:30 HOURS (113 basic units)	
24109	<b>Fee:</b> \$2,237.40 <b>Benefit:</b> 75% = \$1678.05 85% =	- \$2155.70
24107	19:31 HOURS TO 19:40 HOURS (114 basic units)	- 42155.70
24110	<b>Fee:</b> \$2,257.20 <b>Benefit:</b> 75% = \$1692.90 85% =	- \$2175.50
24110	19:41 HOURS TO 19:50 HOURS (115 basic units)	- \$2173.30
0.4.1.1.1		\$2105.20
24111	Fee: \$2,277.00         Benefit: 75% = \$1707.75         85% =           19:51 HOURS TO 20:00 HOURS (116 basic units)	= \$2195.30
	× /	
24112	<b>Fee:</b> \$2,296.80 <b>Benefit:</b> 75% = \$1722.60 85% =	= \$2215.10
	20:01 HOURS TO 20:10 HOURS (117 basic units)	
24113	<b>Fee:</b> \$2,316.60 <b>Benefit:</b> 75% = \$1737.45 85% =	= \$2234.90
	20:11 HOURS TO 20:20 HOURS (118 basic units)	
24114	Fee: \$2,336.40         Benefit: 75% = \$1752.30         85% =	= \$2254.70
	20:21 HOURS TO 20:30 HOURS (119 basic units)	
24115	<b>Fee:</b> \$2,356.20 <b>Benefit:</b> 75% = \$1767.15 85% =	= \$2274.50
	20:31 HOURS TO 20:40 HOURS (120 basic units)	
24116	<b>Fee:</b> \$2,376.00 <b>Benefit:</b> 75% = \$1782.00 85% =	= \$2294.30
	20:41 HOURS TO 20:50 HOURS (121 basic units)	
24117	<b>Fee:</b> \$2,395.80 <b>Benefit:</b> 75% = \$1796.85 85% =	= \$2314.10
24117	ree: \$2,395.80 Benefit: 75% = \$1796.85 85% =	= \$2514.10

T10. RE	LATIVE VALUE GUIDE FOR	
ANAES	THESIA - MEDICARE BENEFITS ARE	
	AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN	
ELIGIBI	-E SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	20:51 HOURS TO 21:00 HOURS (122 basic units)	)
24118	<b>Fee:</b> \$2,415.60 <b>Benefit:</b> 75% = \$1811.70 85%	6 = \$2333.90
	21:01 HOURS TO 21:10 HOURS (123 basic units)	)
24119	<b>Fee:</b> \$2,435.40 <b>Benefit:</b> 75% = \$1826.55 85%	6 = \$2353.70
	21:11 HOURS TO 21:20 HOURS (124 basic units)	)
24120	<b>Fee:</b> \$2,455.20 <b>Benefit:</b> 75% = \$1841.40 85%	6 = \$2373.50
	21:21 HOURS TO 21:30 HOURS (125 basic units)	)
24121	<b>Fee:</b> \$2,475.00 <b>Benefit:</b> 75% = \$1856.25 85%	6 = \$2393.30
	21:31 HOURS TO 21:40 HOURS (126 basic units)	)
24122	<b>Fee:</b> \$2,494.80 <b>Benefit:</b> 75% = \$1871.10 85%	6 = \$2413.10
-	21:41 HOURS TO 21:50 HOURS (127 basic units)	)
24123	<b>Fee:</b> \$2,514.60 <b>Benefit:</b> 75% = \$1885.95 85%	6 = \$2432.90
	21:51 HOURS TO 22:00 HOURS (128 basic units)	)
24124	<b>Fee:</b> \$2,534.40 <b>Benefit:</b> 75% = \$1900.80 85%	6 = \$2452.70
	22:01 HOURS TO 22:10 HOURS (129 basic units)	)
24125	<b>Fee:</b> \$2,554.20 <b>Benefit:</b> 75% = \$1915.65 85%	6 = \$2472.50
	22:11 HOURS TO 22:20 HOURS (130 basic units)	)
24126	<b>Fee:</b> \$2,574.00 <b>Benefit:</b> 75% = \$1930.50 85%	6 = \$2492.30
	22:21 HOURS TO 22:30 HOURS (131 basic units)	)
24127	<b>Fee:</b> \$2,593.80 <b>Benefit:</b> 75% = \$1945.35 85%	6 = \$2512.10
	22:31 HOURS TO 22:40 HOURS (132 basic units)	)
24128	<b>Fee:</b> \$2,613.60 <b>Benefit:</b> 75% = \$1960.20 85%	6 = \$2531.90
	22:41 HOURS TO 22:50 HOURS (133 basic units)	)
24129	<b>Fee:</b> \$2,633.40 <b>Benefit:</b> 75% = \$1975.05 85%	6 = \$2551.70
	22:51 HOURS TO 23:00 HOURS (134 basic units)	)
24130	<b>Fee:</b> \$2,653.20 <b>Benefit:</b> 75% = \$1989.90 85%	6 = \$2571.50
	23:01 HOURS TO 23:10 HOURS (135 basic units)	)
24131	<b>Fee:</b> \$2,673.00 <b>Benefit:</b> 75% = \$2004.75 85%	6 = \$2591.30
	23:11 HOURS TO 23:20 HOURS (136 basic units)	
24132	<b>Fee:</b> \$2,692.80 <b>Benefit:</b> 75% = \$2019.60 85%	6 = \$2611.10

T40 DE	RELATIVE VALUE GUIDE FOR	
ANAES	ELATIVE VALUE GUIDE FOR ESTHESIA - MEDICARE BENEFITS ARE Y PAYABLE FOR ANAESTHESIA	
-	FORMED IN ASSOCIATION WITH AN	
ELIGIB	SIBLE SERVICE 21. ANAESTHESIA/PERFU	JSION TIME UNITS
	23:21 HOURS TO 23:30 HOURS (137 basic units)	
24133	<b>Fee:</b> \$2,712.60 <b>Benefit:</b> 75% = \$2034.45 85% = \$2630.90	
	23:31 HOURS TO 23:40 HOURS (138 basic units)	
24134	<b>Fee:</b> \$2,732.40 <b>Benefit:</b> 75% = \$2049.30 85% = \$2650.70	
	23:41 HOURS TO 23:50 HOURS (139 basic units)	
24135	<b>Fee:</b> \$2,752.20 <b>Benefit:</b> 75% = \$2064.15 85% = \$2670.50	
	23:51 HOURS TO 24:00 HOURS (140 basic units)	
24136	<b>Fee:</b> \$2,772.00 <b>Benefit:</b> 75% = \$2079.00 85% = \$2690.30	
	RELATIVE VALUE GUIDE FOR	
	ESTHESIA - MEDICARE BENEFITS ARE Y PAYABLE FOR ANAESTHESIA	
PERFO	FORMED IN ASSOCIATION WITH AN 22. ANAESTHESIA/PERFU	
ELIGIB	GIBLE SERVICE UNITS - P	HYSICAL STATUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Onl Anaesthesia Performed In Association With An Eligible Service	y Payable For
	Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical S	Status
	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA	
	(a) for anaesthesia performed in association with an item in the range 20100 to 219 22905; or	97 or 22900 to
	(b) for perfusion performed in association with item 22060; or	
	(c) for assistance at anaesthesia performed in association with items 25200 to 2520.	5
	Where the patient has severe systemic disease equivalent to ASA physical status in units)	dicator 3 (1 basic
25000	(See para TN.10.3 of explanatory notes to this Category)           Fee: \$19.80         Benefit: 75% = \$14.85         85% = \$16.85	
	Where the patient has severe systemic disease which is a constant threat to life equiphysical status indicator 4 (2 basic units)	valent to ASA
25005	(See para TN.10.3 of explanatory notes to this Category)           Fee: \$39.60         Benefit: 75% = \$29.70         85% = \$33.70	
	For a patient who is not expected to survive for 24 hours with or without the operat ASA physical status indicator 5 (3 basic units)	ion, equivalent to
25010	(See para TN.10.3 of explanatory notes to this Category) <b>Fee:</b> \$59.40 <b>Benefit:</b> 75% = \$44.55 85% = \$50.50	

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

#### 23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER

		tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service
		Subgroup 23. Anaesthesia/Perfusion Modifying Units - Other
	ANAESTHESIA	, PERFUSION OR ASSISTANCE AT ANAESTHESIA
	- where the patie	nt is less than 12 months of age or 70 years or greater (1 basic units)
25015	<b>Fee:</b> \$19.80	<b>Benefit:</b> 75% = \$14.85 85% = \$16.85
	ANAESTHESIA	, PERFUSION OR ASSISTANCE AT ANAESTHESIA
		nt requires immediate treatment without which there would be significant threat to life t being a service associated with a service to which item 25025 or 25030 or 25050 (nits)
25020	(See para TN.10.3 <b>Fee:</b> \$39.60	of explanatory notes to this Category) Benefit: 75% = \$29.70 85% = \$33.70
PERFO	PAYABLE FOR AI ORMED IN ASSOC	
		MODIFIE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
	Group T10. Rela	MODIFIE tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service
	Group T10. Rela Anaesthesia Pe EMERGENCY immediate treatm than 50% of the t the period from 8 - not being a serv units)	MODIFIE         tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         formed In Association With An Eligible Service         Subgroup 24. Anaesthesia After Hours Emergency Modifier         ANAESTHESIA performed in the after hours period where the patient requires         tion the emergency anaesthesia service is provided in the after hours period, being to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday ice associated with a service to which item 25020, 25030 or 25050 applies (0 basic
	Group T10. Rela Anaesthesia Pe EMERGENCY A immediate treatm than 50% of the t the period from & - not being a serv units) (See para TN.10.3 Derived Fee: Am item/s in the range	MODIFIE         tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         formed In Association With An Eligible Service         Subgroup 24. Anaesthesia After Hours Emergency Modifier         ANAESTHESIA performed in the after hours period where the patient requires         nent without which there would be significant threat to life or body part and where mor         ime for the emergency anaesthesia service is provided in the after hours period, being         opm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday         ice associated with a service to which item 25020, 25030 or 25050 applies (0 basic         of explanatory notes to this Category)         additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia         20100 - 21997 or 22900, plus (b) an item in the range 23010 - 24136, plus (c) where applicable         e 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in
25025	Group T10. Rela Anaesthesia Pe EMERGENCY A immediate treatm than 50% of the t the period from & - not being a serv units) (See para TN.10.3 Derived Fee: Am item/s in the range an item in the range the range 22001-22 ASSISTANCE A immediate treatm than 50% of the t	MODIFIE         tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For         formed In Association With An Eligible Service         Subgroup 24. Anaesthesia After Hours Emergency Modifier         ANAESTHESIA performed in the after hours period where the patient requires         nent without which there would be significant threat to life or body part and where mor         ime for the emergency anaesthesia service is provided in the after hours period, being         pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday         ice associated with a service to which item 25020, 25030 or 25050 applies (0 basic         of explanatory notes to this Category)         additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia         20100 - 21997 or 22900, plus (b) an item in the range 23010 - 24136, plus (c) where applicable         e 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in         051         AFTER HOURS EMERGENCY ANAESTHESIA where the patient requires         nent without which there would be significant threat to life or body part and where mor         ime for which the assistant is in professional attendance on the patient is provided in         priod, being the period from 8pm to 8am on any weekday, or at any time on a Saturday,         blic holiday - not being a service associated with a service to which item 25020, 25025

ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER
	<ul> <li>(a) an assistant anaesthesia item in the range 252</li> <li>(b) an item in the range 23010 - 24136, plus</li> <li>(c) where applicable, an item in the range 25000</li> <li>(d) where performed, any associated therapeutic</li> </ul>	-
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	25. PERFUSION AFTER HOURS EMERGENCY MODIFIER
	Group T10. Relative Value Guide For Ana Anaesthesia Performed In Association W	aesthesia - Medicare Benefits Are Only Payable For /ith An Eligible Service
	Subgroup 25. Per	fusion After Hours Emergency Modifier
	<ul> <li>which there would be significant threat to lisservice is provided in the after hours period any time on a Saturday, a Sunday or a public which item 25020, 25025 or 25030 applies</li> <li>(See para TN.10.3 of explanatory notes to this C Derived Fee: An additional amount of 50% of (a) item 22060, plus</li> <li>(b) an item in the range 23010 - 24136, plus</li> <li>(c) where applicable, an item in the range 25000</li> </ul>	Category) 5 the fee for the perfusion service. That is: 9 - 25015, plus
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	or diagnostic service/s in the range 22001-22051 or 22065-22075 26. ASSISTANCE AT ANAESTHESIA
	Group T10. Relative Value Guide For Ana Anaesthesia Performed In Association W	aesthesia - Medicare Benefits Are Only Payable For /ith An Eligible Service
	Subgroup	26. Assistance At Anaesthesia
		ON OF ANAESTHESIA on a patient in imminent danger of gency treatment, to the exclusion of all other patients (5 basic
25200		Category) ts) plus an item in the range 23010 - 24136 plus, where applicable - performed, any associated therapeutic or diagnostic service/s in the
25200	5	
25200	ASSISTANCE IN THE ADMINISTRATION	ON OF ELECTIVE ANAESTHESIA where:

ANAES ONLY P PERFOI	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 26. ASSISTANCE AT ANAESTHESIA
	(ii) the patient is a neonate or a complex paediatric case; or
	(iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or
	(iv) the patient is critically ill, with multiple organ failure; or
	(v) where the anaesthesia time exceeds 6 hours
	and the assistance is provided to the exclusion of all other patients (5 basic units)
	(See para TN.10.9 of explanatory notes to this Category) <b>Derived Fee:</b> An amount of \$99.0 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051
T11. BO	TULINUM TOXIN INJECTIONS
	Group T11. Botulinum Toxin Injections
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day
18350	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$124.85 <b>Benefit:</b> 75% = \$93.65 85% = \$106.15
	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day
18351	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$124.85         Benefit: 75% = \$93.65         85% = \$106.15
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day
18353	(See para TN.11.1 of explanatory notes to this Category)         Fee: \$249.75       Benefit: 75% = \$187.35       85% = \$212.30
	Botulinum Toxin Type A Purified Neurotixin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity in an ambulant cerebral palsy patient, if:
	(a) the patient is at least 2 years of age; and
	(b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.)
18354	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$124.85 <b>Benefit:</b> 75% = \$93.65 85% = \$106.15
18360	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of

T11. BO	TULINUM TOXIN INJECTIONS
	moderate to severe focal spasticity, if:
	(a) the patient is at least 18 years of age; and
	(b) the spasticity is associated with a previously diagnosed neurological disorder; and
	(c) treatment is provided as:
	(i) second line therapy when standard treatment for the conditions has failed; or
	(ii) an adjunct to physical therapy; and
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and
	(e) the treatment is not provided on the same occasion as a service mentioned in item 18365
	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$124.85 <b>Benefit:</b> 75% = \$93.65 85% = \$106.15
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if:
	(a) the patient is at least 2 years of age, and
	(b) for a patient who is at least 18 years of age - before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and
	(c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.)
18361	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$124.85         Benefit: 75% = \$93.65         85% = \$106.15
	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if:
	(a) the patient is at least 12 years of age; and
	(b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and
	(c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and
	(d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.)
18362	(See para TN.11.1 of explanatory notes to this Category)Fee: $$246.70$ Benefit: $75\% = $185.05$ $85\% = $209.70$
18365	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following a stroke, if:

T11. BO	TULINUM TOXIN INJECTIONS
	(a) the patient is at least 18 years of age; and
	(b) treatment is provided as:
	(i) second line therapy when standard treatment for the condition has failed; or
	(ii) an adjunct to physical therapy; and
	(c) the patient does not have established severe contracture in the limb that is to be treated; and
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and
	(e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment
	(See para TN.11.1 of explanatory notes to this Category)Fee: $$124.85$ Benefit: $75\% = $93.65$ $85\% = $106.15$
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.)
18366	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$156.40 <b>Benefit:</b> 75% = \$117.30 85% = \$132.95
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day
18368	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$267.05         Benefit: 75% = \$200.30         85% = \$227.00
	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)
18369	(See para TN.11.1 of explanatory notes to this Category)           Fee: \$45.05         Benefit: 75% = \$33.80         85% = \$38.30
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)
18370	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$45.05 <b>Benefit:</b> 75% = \$33.80 85% = \$38.30
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.)
18372	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$124.85 <b>Benefit:</b> 75% = \$93.65 85% = \$106.15
	Clostridium Botulinum Type A Toxin-Haemagglutin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)
18374	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$124.85 <b>Benefit:</b> 75% = \$93.65 85% = \$106.15

	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with
	cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:
	(a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with:
	(i) multiple sclerosis; or
	(ii) spinal cord injury; or
	(iii) spina bifida and who is at least 18 years of age; and
	(b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and
	(c) the patient is willing and able to self-catheterise; and
	(d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and
	(e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919
	For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.)
18375	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$229.85 <b>Benefit:</b> 75% = \$172.40
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if:
	(a) the patient is at least 18 years of age; and
18377	(b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3

T11. BOT	ULINUM TOXIN INJECTIONS
	prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin; and
	(c) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with
	For each patient-applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration)
	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$124.85 <b>Benefit:</b> 75% = \$93.65 85% = \$106.15
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:
	(a) the urinary incontinence is due to idiopathic overactive bladder in a patient: and
	(b) the patient is at least 18 years of age; and
	(c) the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anti-
	cholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week
	before commencement of treatment with botulinum toxin; and
	(d) the patient is willing and able to self-catheterise; and
	(e) treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919
	For each patient-applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment
	(H) (Anaes.)
18379	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$229.85 <b>Benefit:</b> 75% = \$172.40

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