Australian Government
Department of Health and Ageing

Medicare Benefits Schedule Book

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

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

TABLE OF CONTENTS

G.1.1. The Medicare Benefits Schedule - Introduction....9
G.1.2. Medicare - an outline....10
G.1.3. Medicare benefits and billing practices....10
G.2.1. Provider eligibility for Medicare....11
G.2.2. Provider Numbers....11
G.2.3. Locum tenens....12
G.2.4. Overseas trained doctor....12
G.2.5. Addresses of Medicare Australia, Schedule Interpretation and Changes to Provider Details....12
G.3.1. Patient eligibility for Medicare....13
G.3.2. Medicare cards....13
G.3.3. Visitors to Australia and temporary residents....13
G.3.4. Reciprocal Health Care Agreements....13
G.4.1. General Practice....14
G.5.1. Recognition as a Specialist or Consultant Physician....15
G.5.2. Emergency Medicine....16
G.6.1. Referral Of Patients To Specialists Or Consultant Physicians....16
G.7.1. Billing procedures....19
G.8.1. Provision for review of individual health professionals....22
G.8.2. Medicare Participation Review Committee....23
G.8.3. Referral of professional issues to regulatory and other bodies....23
G.8.4. Comprehensive Management Framework for the MBS....24
G.8.5. Medical Services Advisory Committee....24
G.8.6. Pathology Services Table Committee....24
G.8.7. Medicare Claims Review Panel....24
G.9.1. Penalties and Liabilities....24
G.10.1. Schedule fees and Medicare benefits....24
G.10.2. Medicare safety nets....25
G.11.1. Services not listed in the MBS....26
G.11.2. Ministerial Determinations....26
G.12.1. Professional services....26
G.12.2. Services rendered on behalf of medical practitioners....27
G.12.3. Mass immunisation....27
G.13.1. Services which do not attract Medicare benefits....27
G.14.1. Principles of interpretation of the MBS....30
G.14.2. Services attracting benefits on an attendance basis....30
G.14.3. Consultation and procedures rendered at the one attendance....30
G.14.4. Aggregate items....30
G.14.5. Residential aged care facility....30
G.15.1. Practitioners should maintain adequate and contemporaneous records....30
T.1.1. Hyperbaric Oxygen Therapy - (Items 13015, 13020, 13025 and 13030)....34
T.1.2. Haemodialysis - (Items 13100 and 13103)....34
T.1.3. Consultant Physician Supervision of Home Dialysis - (Item 13104)....34
T.1.4. Assisted Reproductive Technology ART Services - (Items 13200 to 13221)....34
T.1.5. Intracytoplasmic Sperm Injection - (Item 13251)....35
T.1.6. Administration of Blood or Bone Marrow already Collected (Item 13706)....35
T.1.7. Collection of Blood - (Item 13709)....35
T.1.8. Intensive Care Units - (Items 13870 to 13888)....36
T.1.9. Procedures Associated with Intensive Care - (Items 13818, 13842, 13847, 13848 and 13857)....36
T.1.10. Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876)....37
T.1.11. Cytotoxic Chemotherapy Administration - (Item 13915)....37
T.1.12. Implanted Pump or Reservoir/Drug Delivery Device - (Items 13939 and 13942)....37
T.1.13. PUVA or UVB Therapy - (Items 14050 and 14053)....38
T.1.14. Laser Photocoagulation - (Items 14106 to 14124)....38
T.1.15. Laser Photocoagulation (Item 14124)....38
T.1.16. Facial Injections of Poly-L-Lactic Acid - (Items 14201 and 14202)....38
T.1.17. Hormone and Living Tissue Implantation - (Items 14203 and 14206)....38
T.1.18. Implantable Drug Delivery System for the Treatment of Severe Chronic Spasticity - (Items 14227 to 14242)....38
T.1.19. Immunomodulating Agent - (Item 14245)....38
T.1.20. Therapeutic procedures may be provided by a specialist trainee (Items 13015 to 51318)....39
T.1.21. Telehealth Specialist Services....39
T.2.1. Radiation Oncology - General....40
T.2.2. Brachytherapy of the Prostate - (Item 15338)....41

T.2.3. Planning Services - (Items 15500 to 15562 and 15850) 41
T.2.4. Treatment Verification - (Items 15700 to 15705, 15710 and 15800) 41
T.3.1. Therapeutic Dose of Yttrium 90 - (Item 16003) 42
T.4.1. Antenatal Service Provided by a Nurse, Midwife or a Registered Aboriginal Health Worker - (Item 16400) 42
T.4.2. Items for Initial and Subsequent Obstetric Attendances (Items 16401 and 16404) 43
T.4.3. Antenatal Care - (Item 16500) 43
T.4.4. External Cephalic Version for Breech Presentation - (Item 16501) 43
T.4.5. Labour and Delivery - (Items 16515, 16518, 16519 and 16525) 43
T.4.6. Caesarean Section - (Item 16520) 44
T.4.7. Complicated Confinement - (Item 16522) 44
T.4.8. Labour and Delivery Where Care is Transferred by a Participating Midwife - (Items 16527 to 16528) 44
T.4.9. Items for Planning and Management of a Pregnancy (Item 16590) 44
T.4.10. Post-Partum Care - (Items 16564 to 16573) 45
T.4.11. Interventional Techniques - (Items 16600 to 16636) 45
T.4.12. Telehealth Specialist Services 45
T.6.1. Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625) 47
T.6.2. Referred Anaesthesia Consultations - (Items 17640 to 17655) 48
T.6.3. Anaesthetist Consultations - Other - (Items 17680, 17690) 49
T.6.4. Telehealth Specialist Services 49
T.7.1. Regional or Field Nerve Blocks - General 51
T.7.2. Maintenance of Regional or Field Nerve Block - (Items 18222 and 18225) 51
T.7.3. Intrathecal or Epidural Injection - (Item 18232) 51
T.7.4. Intrathecal or Epidural Infusion - (Items 18226 and 18227) 51
T.7.5. Regional or Field Nerve Blocks - (Items 18234 to 18298) 51
T.8.1. Surgical Operations 52
T.8.2. Multiple Operation Rule 52
T.8.3. Procedure Performed with Local Infiltration or Digital Block 53
T.8.4. Aftercare (Post-operative Treatment) 53
T.8.5. Abandoned surgery - (Item 30001) 55
T.8.6. Repair of Wound - (Items 30023 to 30049) 55
T.8.7. Biopsy for Diagnostic Purposes - (Items 30071 to 30096) 55
T.8.8. Lipectomy - (Items 30165 to 30177) 55
T.8.9. Treatment of Keratoses, Warts etc (Items 30185, 30186, 30187, 30189, 30192 and 36815) 56
T.8.10. Cryotherapy and Serial Curettage Excision - (Items 30196 to 30203) 56
T.8.11. Telangiectases or Starburst Vessels - (Items 30213 and 30214) 56
T.8.12. Sentinal Node Biopsy for Breast Cancer - (Items 30299 to 30303) 57
T.8.13. Dissection of Axillary Lymph Nodes - (Items 30335 and 30336) 57
T.8.14. Laparotomy and Other Procedures on the Abdominal Viscera - (Item 30375) 57
T.8.15. Diagnostic Laparoscopy - (Item 30390) 57
T.8.16. Major Abdominal Incision - (Item 30396) 57
T.8.17. Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484 to 30487, 30490 to 30494, 30680 to 30694, 32084 to 32095, 32103, 32104 and 32106) 57
T.8.18. Revision of Gastric Reduction, Gastroplasty or Bypass - (Item 30514) 58
T.8.19. Gastrectomy, Sub-total Radical - (Item 30523) 58
T.8.20. Anti reflux Operations - (Items 30527 to 30533, 31464 and 31466) 58
T.8.21. Endoscopic or Endobronchial Ultrasound +/- Fine Needle Aspiration - (Items 30688 - 30710) 58
T.8.22. Removal of Skin Lesions - (Items 31200 to 31355) 58
T.8.23. Removal of Skin Lesion From Face - (Items 31235 to 31245, 31265 to 31278, 31310 to 31320) 59
T.8.24. Dissection of Lymph Nodes of Neck - (Items 31423 to 31438) 59
T.8.25. Excision of Breast Lesions, Abnormalities or Tumours - Malignant or Benign - (Items 31500 to 31515) 60
T.8.26. Subcutaneous Mastectomy - (Items 31521, 31524 and 31527) 60
T.8.27. Fine Needle Aspiration of Breast Lesion - (Item 31533) 60
T.8.28. Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation - (Items 31539 and 31545) 60
T.8.29. Preoperative Localisation of Breast Lesion Prior to the Use of Advanced Breast Biopsy Instrumentation - (Item 31542) 60
T.8.30. Per Anal Excision of Rectal Tumour using Stereoscopic Rectoscopy - (Items 32103, 32104 and 32106) 60
T.8.31. Sacral Nerve Stimulation for Faecal Incontinance - (Items 32213 to 32218) 60
T.8.32. Artificial Bowel Sphincter (items 32220, 32221) 61
T.8.33. Varicose veins - (Items 32500 to 32517) 61
T.8.34. Endovenous Laser Therapy (Items 32520 and 32522) 61
T.8.35. Uterine Artery Embolisation - (Item 35410) 62
T.8.36. Endovascular Coiling of Intracranial Aneurysms - (Item 35412) 62
T.8.37. Arterial and Venous Patches - (Items 33545 to 33551and 34815) 62
T.8.38. Embolectomy or Thrombectomy - (Item 33806) 62
T.8.39. Carotid Percutaneous Transluminal Angioplasty with Stenting - (Item 35307) 62
T.8.40. Peripheral Arterial or Venous Catheterisation - (Item 35317) 62
T.8.41. Peripheral Arterial or Venous Embolisation - (Item 35321) 62
T.8.42. Selective Internal Radiation Therapy (SIRT) using SIR-Spheres - (Items 35404, 35406 and 35408) 62
T.8.43. Percutaneous Transluminal Coronary Angioplasty - (Items 38309, 38312, 38315 and 38318) 63
T.8.44. Colposcopic Examination - (Item 35614) 63
T.8.45. Hysteroscopy - (Item 35626) 63
T.8.46. Curettage of Uterus under GA or Major Nerve Block - (Items 35639 and 35640) 63

T.8.47. Neoplastic Changes of the Cervix - (Items 35644-35648) 63
T.8.48. Sterilisation of Minors - Legal Requirements - (Items 35657, 35687, 35688, 35691, 37622 and 37623) 63
T.8.49. Debulking of Uterus - (Item 35658) 63
T.8.50. Nephrectomy - (Items 36526 and 36527) 63
T.8.51. Sacral Nerve Stimulation - (Items 36658, 36660, and 36662) 63
T.8.52. Sacral Nerve Stimulation (items 36663-36668) 64
T.8.53. Ureteroscopy - (Item 36803) 64
T.8.54. Selective Coronary Angiography - (Items 38215 to 38246) 64
T.8.55. Transurethral Needle Ablation (TUNA) of the Prostate - (Items 37201 and 37202) 64
T.8.56. Gold Fiducial Markers into the Prostate - (item 37217) 64
T.8.57. Brachytherapy of the Prostate - (Item 37220) 65
T.8.58. High Dose Rate Brachytherapy - (Item 37227) 65
T.8.59. Radical or Debulking Operation for Ovarian Tumour - (Item 35720) 65
T.8.60. Transcutaneous Sperm Retrieval - (Item 37605) 65
T.8.61. Surgical Sperm Retrieval, by Open Approach - (Item 37606) 65
T.8.62. Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356) 65
T.8.63. Implantable ECG Loop Recorder - (Item 38285) 65
T.8.64. Transluminal Insertion of Stent or Stents - (Item 38306) 66
T.8.65. Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654) 66
T.8.66. Intravascular Extraction of Permanent Pacing Leads - (Item 38358) 66
T.8.67. Cardiac Resynchronisation Therapy - (Item 38371) 66
T.8.68. Implantable Cardioverter Defibrillator - (Items 38384 and 38387) 66
T.8.69. Cardiac and Thoracic Surgical Items - (Items 38470 to 38766) 66
T.8.70. Coronary Artery Bypass - (Items 38497 to 38504) 66
T.8.71. Re-operation via Median Sternotomy - (Item 38640) 66
T.8.72. Skull Base Surgery - (Items 39640 to 39662) 67
T.8.73. Intradiscal Injection of Chymopapain - (Item 40336) 67
T.8.74. Removal of Ventilating Tube from Ear - (Item 41500) 67
T.8.75. Meatoplasty - (Item 41515) 67
T.8.76. Reconstruction of Auditory Canal - (Item 41524) 67
T.8.77. Removal of Nasal Polyp or Polypi - (Items 41662, 41665 and 41668) 67
T.8.78. Larynx, Direct Examination - (Item 41846) 67
T.8.79. Microlaryngoscopy - (Item 41858) 67
T.8.80. Imbedded Foreign Body - (Item 42644) 67
T.8.81. Corneal Incisions - (Item 42672) 67
T.8.82. Capsulectomy or Lensectomy - (Item 42731) 67
T.8.83. Posterior Juxtascleral Depot injection - (Item 42741) 68
T.8.84. Cyclodestructive Procedures - (Items 42770 and 42771) 68
T.8.85. Laser Trabeculoplasty - (Items 42782 and 42783) 68
T.8.86. Laser Iridotomy - (Items 42785 and 42786) 68
T.8.87. Laser Capsulotomy - (Items 42788 and 42789) 69
T.8.88. Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Items 42791 and 42792) 69
T.8.89. Division of Suture by Laser - (Item 42794) 69
T.8.90. Laser Coagulation of Corneal or Scleral Blood Vessels - (Item 42797) 69
T.8.91. Ophthalmic Sutures - (Item 42845) 69
T.8.92. Full face Chemical Peel - (Items 45019 and 45020) 70
T.8.93. Abrasive Therapy/Resurfacing - (Items 45021 to 45026) 70
T.8.94. Foreign Implant - (Item 45051) 70
T.8.95. Escharotomy - (Item 45054) 70
T.8.96. Local Skin Flap - Definition 70
T.8.97. Free Grafting to Burns - (Items 45406 to 45418) 71
T.8.98. Revision of Scar - (Items 45506 to 45518) 71
T.8.99. Reduction Mammaplasty - (Item 45522) 71
T.8.100. Augmentation Mammaplasty - (Items 45524, 45527 and 45528) 71
T.8.101. Breast Reconstruction, Myocutaneous Flap - (Item 45530) 71
T.8.102. Breast Prosthesis, Removal and Replacement of - (Items 45552 to 45555) 72
T.8.103. Breast Ptosis - (Items 45556 to 45559) 72
T.8.104. Nipple and/or Areola Reconstruction - (Items 45545 and 45546) 72
T.8.105. Liposuction - (Items 45584, 45585 and 45586) 72
T.8.106. Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588) 73
T.8.107. Reduction of Eyelids - (Items 45617 and 45620) 73
T.8.108. Rhinoplasty - (Items 45638, 45639) 73
T.8.109. Contour Restoration - (Item 45647) 73
T.8.110. Vermilionectomy - (Item 45669) 74
T.8.111. Osteotomy of Jaw - (Items 45720 to 45752) 74
T.8.112. Genioplasty - (Item 45761) 74
T.8.113. Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813) 74
T.8.114. Fracture of Mandible or Maxilla - (Items 45975 to 45996) 74
T.8.115. Reduction of Dislocation or Fracture 74
T.8.116. Removal of Multiple Exostoses (Items 47933 and 47936) 74
T.8.117. Lumbar Discectomy - (Item 48636) 74

T.8.118. Discectomy in Relation to Anterior Interbody Spinal Fusion - (Items 48660 to 48675) 74
T.8.119. Internal Fixation - (Items 48678 to 48690) 74
T.8.120. Wrist Surgery - (Items 49200 to 49227) 75
T.8.121. Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563) 75
T.8.122. Paediatric Patients - (Items 50450 to 50658) 75
T.8.123. Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588) 75
T.8.124. Non-resectable Hepatocellular Carcinoma Destruction of by Open or Laparoscopic Radiofrequency Ablation - (Item 50952) 75
T.9.1. Assistance at Operations - (Items 51300 to 51318) 75
T.9.2. Benefits Payable under Item 51300 76
T.9.3. Benefits Payable Under Item 51303 76
T.9.4. Benefits Payable Under Item 51309 76
T.9.5. Assistance at Cataract and Intraocular Lens Surgery - (Item 51318) 76
T.10.1. Relative Value Guide For Anaesthetics - (Group T10) 76
T.10.2. Eligible Services 78
T.10.3. RVG Unit Values 78
T.10.4. Deriving the Schedule Fee under the RVG 80
T.10.5. Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation) 80
T.10.6. Account Requirements 81
T.10.7. General Information 81
T.10.8. Additional Services Performed in Connection with Anaesthesia - Subgroup 19 82
T.10.9. Assistance in the Administration of Anaesthesia 82
T.10.10. Perfusion Services - (Items 22055 to 22075) 83
T.10.11. Anaesthesia as a Therapeutic Procedure - (Item 21965) 83
T.10.12. Discontinued Procedure - (Item 21990) 83
T.10.13. Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997) 83
T.10.14. Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905) 84
T.10.15. Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172) 84
T.10.16. Anaesthesia in Connection with an Oral and MaxillofaciaI Service - (Category 4 of the Medicare Benefits Schedule) 84
T.10.17. Intra-operative Blocks for Post Operative Pain - (Items 22031 to 22050) 84
T.10.18. Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192) 84
T.10.19. Intrathecal or Epidural Injection for Control of Post-operative Pain - Initial - (Item 22031) 84
T.10.20. Intrathecal or Epidural Injection for Control of Post-operative Pain - Subsequent - (Item 22036) 84
T.10.21. Regional or Field Nerve Blocks for Post-operative Pain - (Items 22040 - 22050) 84
T.10.22. Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474) 84
T.10.23. Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670) 84
T.10.24. Anaesthesia for Femoral Artery Embolectomy - (Item 21274) 84
T.10.25. Anaesthesia for Cardiac Catheterisation - (Item 21941) 85
T.10.26. Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936) 85
T.10.27. Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and7) 85
T.10.28. Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865) 85
T.10.29. Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911) 85
T.11.1. Botulinum Toxin - (Items 18350 to 18373) 85
GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES 88
SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY 88
SUBGROUP 2 - DIALYSIS 88
SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES 89
SUBGROUP 4 - PAEDIATRIC & NEONATAL 90
SUBGROUP 5 - CARDIOVASCULAR 90
SUBGROUP 6 - GASTROENTEROLOGY 91
SUBGROUP 8 - HAEMATOLOGY 91
SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT 92
SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT 92
SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES 93
SUBGROUP 12 - DERMATOLOGY 94
SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES 95
GROUP T2 - RADIATION ONCOLOGY 97
SUBGROUP 1 - SUPERFICIAL 97
SUBGROUP 2 - ORTHOVOLTAGE 97
SUBGROUP 3 - MEGAVOLTAGE 97
SUBGROUP 4 - BRACHYTHERAPY 99
SUBGROUP 5 - COMPUTERISED PLANNING 101
SUBGROUP 6 - STEREOTACTIC RADIOSURGERY 103
SUBGROUP 7 - RADIATION ONCOLOGY TREATMENT VERIFICATION 103
SUBGROUP 8 - BRACHYTHERAPY PLANNING AND VERIFICATION 103
GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE 104
GROUP T4 - OBSTETRICS 105
GROUP T6 - ANAESTHETICS 110
SUBGROUP 1 - ANAESTHESIA CONSULTATIONS 110
GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS 112
GROUP T11 - BOTULINUM TOXIN INJECTIONS 115

GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - Medicare Benefits are only payable for anaesthesia performed in association with an eligible service 117
SUBGROUP 1 - HEAD 117
SUBGROUP 2 - NECK....118
SUBGROUP 3 - THORAX....119
SUBGROUP 4 - INTRATHORACIC 120
SUBGROUP 5 - SPINE AND SPINAL CORD 120
SUBGROUP 6 - UPPER ABDOMEN 121
SUBGROUP 7 - LOWER ABDOMEN 122
SUBGROUP 8 - PERINEUM 124
SUBGROUP 9 - PELVIS (EXCEPT HIP) 125
SUBGROUP 10 - UPPER LEG (EXCEPT KNEE) 126
SUBGROUP 11 - KNEE AND POPLITEAL AREA....127
SUBGROUP 12 - LOWER LEG (BELOW KNEE)....128
SUBGROUP 13 - SHOULDER AND AXILLA 129
SUBGROUP 14 - UPPER ARM AND ELBOW....130
SUBGROUP 15 - FOREARM WRIST AND HAND 131
SUBGROUP 16 - ANAESTHESIA FOR BURNS 132
SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES....132
SUBGROUP 18 - MISCELLANEOUS 134
SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES 134
SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE....136
SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS 136
SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS....143
SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER....144
SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER....144
SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER 144
SUBGROUP 26 - ASSISTANCE AT ANAESTHESIA 144
GROUP T8 - SURGICAL OPERATIONS 146
SUBGROUP 1 - GENERAL....146
SUBGROUP 2 - COLORECTAL 175
SUBGROUP 3 - VASCULAR 180
VARICOSE VEINS 180
BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE....181
BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS....182
ENDARTERECTOMY AND ARTERIAL PATCH....184
EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA....185
LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS 186
OPERATIONS FOR VASCULAR ACCESS 188
COMPLEX VENOUS OPERATIONS 189
SYMPATHECTOMY 189
DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE 189
MISCELLANEOUS VASCULAR PROCEDURES....190
ENDOVASCULAR INTERVENTIONAL PROCEDURES 190
INTERVENTIONAL RADIOLOGY PROCEDURES 191
SUBGROUP 4 - GYNAECOLOGICAL....192
SUBGROUP 5 - UROLOGICAL....199
GENERAL 199
OPERATIONS ON BLADDER....202
OPERATIONS ON PROSTATE 205
OPERATIONS ON URETHRA, PENIS OR SCROTUM 207
OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES 209
PAEDIATRIC GENITURINARY SURGERY 210
SUBGROUP 6 - CARDIO-THORACIC....211
CARDIOLOGY PROCEDURES....211
CATHETER BASED ARRHYTHMIA ABLATION 213
ENDOVASCULAR INTERVENTIONAL PROCEDURES 213
MISCELLANEOUS CARDIAC PROCEDURES 214
THORACIC SURGERY 215
CARDIAC SURGERY PROCEDURES....217
VALVULAR PROCEDURES 217
SURGERY FOR ISCHAEMIC HEART DISEASE....218
ARRHYTHMIA SURGERY 219
PROCEDURES ON THORACIC AORTA....219
TECHNIQUES FOR PRESERVATION OF ARRESTED HEART 220
CIRCULATORY SUPPORT PROCEDURES....220
RE-OPERATION....221
MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES 221
CARDIAC TUMOURS....221
CONGENITAL CARDIAC SURGERY 222
MISCELLANEOUS PROCEDURES ON THE CHEST 223

SUBGROUP 7 - NEUROSURGICAL 223
GENERAL 223
PAIN RELIEF 224
PERIPHERAL NERVES 225
CRANIAL NERVES 226
CRANIO-CEREBRAL INJURIES 226
SKULL BASE SURGERY 226
INTRA-CRANIAL NEOPLASMS 227
CEREBROVASCULAR DISEASE 228
INFECTION 228
CEREBROSPINAL FLUID CIRCULATION DISORDERS 228
CONGENITAL DISORDERS 228
SPINAL DISORDERS 229
SKULL RECONSTRUCTION 230
EPILEPSY 230
STEREOTACTIC PROCEDURES 230
MISCELLANEOUS 232
SUBGROUP 8 - EAR, NOSE AND THROAT 232
SUBGROUP 9 - OPHTHALMOLOGY 239
SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS 249
ACUTE 249
CHRONIC 249
SUBGROUP 11 - PAEDIATRIC 249
SURGERY IN NEONATE OR YOUNG CHILD 249
THORACIC SURGERY 251
ABDOMINAL SURGERY 251
MISCELLANEOUS SURGERY 252
SUBGROUP 12 - AMPUTATIONS 253
SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY 254
GENERAL 254
SKIN FLAP SURGERY 255
FREE GRAFTS 256
OTHER GRAFTS AND MISCELLANEOUS PROCEDURES 258
ORAL AND MAXILLOFACIAL SURGERY 267
SUBGROUP 14 - HAND SURGERY 271
SUBGROUP 15 - ORTHOPAEDIC 275
TREATMENT OF DISLOCATIONS 275
TREATMENT OF FRACTURES 277
GENERAL 285
BONE GRAFTS 286
OSTEOTOMY AND OSTEECTOMY 287
EPIPHYSEODESIS 288
SPINE 288
SHOULDER 290
ELBOW 291
WRIST 292
HIP 293
KNEE 294
ANKLE 296
FOOT 296
OTHER JOINTS 298
MALIGNANT DISEASE 298
LIMB LENGTHENING AND DEFORMITY CORRECTION 299
SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY 302
TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS 304
SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS 306
TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS 307
SUBGROUP 16 - RADIOFREQUENCY ABLATION 307
GROUP T9 - ASSISTANCE AT OPERATIONS 308
INDEX 309

G.1.1. THE MEDICARE BENEFITS SCHEDULE - INTRODUCTION

Schedules of Services

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

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

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

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

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

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

G.1.2. MEDICARE - AN OUTLINE

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

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

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

- i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
- ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker;
- iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
- iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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

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

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

Where a Medicare benefit has been inappropriately paid, Medicare Australia may request its return from the practitioner concerned.

G.1.3. MEDICARE BENEFITS AND BILLING PRACTICES

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

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

Billing practices contrary to the Act

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

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

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

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

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

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

G.2.1. PROVIDER ELIGIBILITY FOR MEDICARE

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

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

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

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

Non-medical practitioners
To be eligible to provide services which will attract Medicare benefits under MBS items 10950-10977 and MBS items 80000-88000 and 82100-82140 and 82200-82215, allied health professionals, dentists, and dental specialists, participating midwives and participating nurse practitioners must be
(a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
(b) registered with Medicare Australia to provide these services.

G.2.2. PROVIDER NUMBERS

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

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

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

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

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

G.2.3. LOCUM TENENS

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

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

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

G.2.4. OVERSEAS TRAINED DOCTOR

Ten year moratorium

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

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

Exclusions - Practitioners who **before 1 January 1997** had

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

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

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

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

NEW SOUTH WALES Medicare Australia Paramatta Office 130 George Street PARRAMATTA NSW 2150	**VICTORIA** Medicare Australia Melbourne Office Level 10 595 Collins Street MELBOURNE VIC 3000	**QUEENSLAND** Medicare Australia Brisbane Office 143 Turbot Street BRISBANE QLD 4000
SOUTH AUSTRALIA Medicare Australia Adelaide Office 209 Greenhill Road	**WESTERN AUSTRALIA** Medicare Australia Perth Office Level 4	**TASMANIA** Medicare Australia Hobart Office 199 Collins Street

EASTWOOD SA 5063	130 Stirling Street PERTH WA 6003	HOBART TAS 7000
NORTHERN TERRITORY As per South Australia	**AUSTRALIAN CAPITAL TERRITORY** Medicare Australia National Office 134 Reed Street North GREENWAY ACT 2901	

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

Provider Enquiries: 132 150
Public Enquiries: 132 011

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

G.3.1. Patient eligibility for Medicare

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

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

G.3.2. Medicare cards

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

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

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

G.3.3. Visitors to Australia and temporary residents

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

G.3.4. Reciprocal Health Care Agreements

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

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

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

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

G.4.1. General Practice

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

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

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

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

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

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

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

Vocational recognition of general practitioners

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

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

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

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

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

Further information on eligibility for recognition should be directed to:

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

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

Executive Assistant, ACRRM:
Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

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

Chief Executive Officer
The Royal Australian College of General Practitioners

College House
1 Palmerston Crescent
SOUTH MELBOURNE VIC 3205

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

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

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

Continued vocational recognition is dependent upon:

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

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

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

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

Removal of vocational recognition status

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

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

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

G.5.1. Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

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

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

G.5.2. EMERGENCY MEDICINE

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

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

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

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

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

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

What is a Referral?

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

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

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

The exceptions to the requirements in paragraph above are that

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

(b) sub-paragraphs (ii) and (iii) do not apply to
- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

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

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:
  (a) by a registered dental practitioner, where the referral arises from a dental service; or
  (b) by a registered optometrist where the specialist is an ophthalmologist; or

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

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

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

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

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

Billing

Routine Referrals

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

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

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

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

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

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

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

However, where the referring practitioner:-
(a) deems it necessary for the patient's condition to be reviewed; and
(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier
the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

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

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 18 months from the date the service was rendered.

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

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

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

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

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

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

G.7.1. BILLING PROCEDURES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under these arrangements:-
- the patient's Medicare number must be quoted on all direct-bill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;

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

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

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

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

Use of Medicare Cards in Direct Billing

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

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

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

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

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

Assignment of Benefit Forms

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

1. Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.
2. Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.
3. Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.
4. Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.
5. Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.
6. Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by Medicare Australia for that purpose.

The Claim for Assigned Benefits (Form DB1N, DB1H)

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

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

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

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

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

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

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

G.8.1. PROVISION FOR REVIEW OF INDIVIDUAL HEALTH PROFESSIONALS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G.8.2. MEDICARE PARTICIPATION REVIEW COMMITTEE

The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who:
(a) has been successfully prosecuted for relevant criminal offences;
(b) has breached an Approved Pathology Practitioner undertaking;
(c) has engaged in prohibited diagnostic imaging practices; or
(d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

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

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

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

The *Health Insurance Act 1973* provides for the following referral, to an appropriate regulatory body:
i. a significant threat to a person's life or health, when caused or is being caused or is likely to be caused by the conduct of the practitioner under review; or
ii. a statement of concerns of non-compliance by a practitioner with 'professional standards'.

G.8.4. Comprehensive Management Framework for the MBS

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

G.8.5. Medical Services Advisory Committee

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

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

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

G.8.6. Pathology Services Table Committee

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

G.8.7. Medicare Claims Review Panel

There are MBS items which make the payment of Medicare benefits dependent on a ‘demonstrated’ clinical need. Services requiring prior approval are those covered by items 11222, 11225, 12207, 12215, 12217, 14124, 21965, 21997, 30214, 32501, 42771, 42783, 42786, 42789, 42792, 45019, 45020, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639_.

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

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

Applications for approval should be addressed to:
The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

G.9.1. Penalties and Liabilities

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

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

G.10.1. Schedule fees and Medicare benefits

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

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been

rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.

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

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

There are presently three levels of Medicare benefit payable:

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

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

(c) **85% of the Schedule fee,** or the Schedule fee less $73.70 (indexed annually), whichever is the greater, for all other professional services.

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

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

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

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

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

G.10.2. MEDICARE SAFETY NETS

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

Original Medicare Safety Net:
Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2012 is $413.50. 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 2012, 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 $598.80. The threshold for all other singles and families is $1,198.00.

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

Individuals are automatically registered with Medicare Australia for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from Medicare Australia offices, or completed online at www.medicareaustralia.gov.au.

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

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

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

For example:

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

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

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

G.11.1. SERVICES NOT LISTED IN THE MBS

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

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

G.11.2. MINISTERIAL DETERMINATIONS

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

G.12.1. PROFESSIONAL SERVICES

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

The H*ealth Insurance Regulations 1975* specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved

(i.e. Items 170-172). The requirement of "personal performance" is met whether or not assistance is provided, according to accepted medical standards:-

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

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

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

G.12.2. SERVICES RENDERED ON BEHALF OF MEDICAL PRACTITIONERS

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

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

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

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

G.12.3. MASS IMMUNISATION

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

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

G.13.1. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

Services not attracting benefits

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

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

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

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

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

(a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;
(b) the injection of human chorionic gonadotrophin in the management of obesity;
(c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
(d) the removal of tattoos;
(e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;
(f) the removal from a cadaver of kidneys for transplantation;
(g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

(a) Endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;
(b) Gamma knife surgery;
(c) Intradiscal electro thermal arthroplasty;
(d) Intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
(e) Intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
(f) Low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
(g) Lung volume reduction surgery, for advanced emphysema;
(h) Photodynamic therapy, for skin and mucosal cancer;
(i) Placement of artificial bowel sphincters, in the management of faecal incontinence;
(j) Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
(k) Specific mass measurement of bone alkaline phosphatase;
(l) Transmyocardial laser revascularisation;
(m) Vertebral axial decompression therapy, for chronic back pain.
(n) Autologous Chondrocyte Implantation and Matrix-induced Autologous Chondrocyte Implantation.
(o) Vertebroplasty

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

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

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

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

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

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

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

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

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

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

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

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

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

G.14.1. PRINCIPLES OF INTERPRETATION OF THE MBS

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

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

G.14.2. SERVICES ATTRACTING BENEFITS ON AN ATTENDANCE BASIS

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

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

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

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

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

G.14.4. AGGREGATE ITEMS

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

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

G.14.5. RESIDENTIAL AGED CARE FACILITY

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

G.15.1. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS

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

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

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

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

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

- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and

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

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

THERAPEUTIC PROCEDURES

CATEGORY 3

SUMMARY OF CHANGES

Changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number

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

New Items

42738 42739

Amended Descriptions

42740

T.1.1. HYPERBARIC OXYGEN THERAPY - (ITEMS 13015, 13020, 13025 AND 13030)

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

(a) is equipped and staffed so that it is capable of providing to a patient:
- hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilo pascal gauge pressure); and
- mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment.

(b) is supported by:
- at least one specialist with training in Diving and Hyperbaric Medicine, or medical practitioner who holds the Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society who is rostered and immediately available to the facility during normal working hours;

(c) and is staffed by:
- a registered medical practitioner with training in Diving and Hyperbaric Medicine who is present in the hyperbaric facility and immediately available at all times when patients are undergoing treatment; and
- a registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Oxygen Facility Industry Guidelines (Draft Australian Standard SF346) who is present during hyperbaric oxygen therapy.

(d) has defined admission and discharge policies.

Item 13015 provides coverage for hyperbaric oxygen treatment of soft tissue radiation injury and radio necrosis, and hypoxic problem wounds in non-diabetic patients. It is funded on an interim basis pending Ministerial decision informed from the MSAC recommendations in 2011 (MSAC review 1054.1).

T.1.2. HAEMODIALYSIS - (ITEMS 13100 AND 13103)

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

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

T.1.3. CONSULTANT PHYSICIAN SUPERVISION OF HOME DIALYSIS - (ITEM 13104)

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

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies (generally monthly);
- Feed-back of results to the home patient and his or her treating general physician;
- Adjustments to medications and dialysis therapies based upon these results;
- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant;
- Referral to, and communication with, other specialists involved in the care of the patient; and
- Being available to advise the patient or the patient's agent.

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

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

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

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

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

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

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

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

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

Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology and Diagnostic Imaging) in lieu of or in conjunction with items 13200 – 13221 but excluding item 13202. Specifically, Medicare benefits are not payable for these items in association with items 104, 105, 14203, 14206, 35637, pathology tests or diagnostic imaging.

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending not more than 30 days later.

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

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

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

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

T.1.5. Intracytoplasmic Sperm Injection - (Item 13251)

Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:
- where fertilisation with standard IVF is highly unlikely to be successful; or
- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

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

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

T.1.6. Administration of Blood or Bone Marrow already Collected (Item 13706)

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

T.1.7. Collection of Blood - (Item 13709)

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

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

T.1.8. INTENSIVE CARE UNITS - (ITEMS 13870 TO 13888)

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

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

(b) is supported by:
  (i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and
  (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
  (iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

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

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

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

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

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

(c) has defined admission and discharge policies.

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

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

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

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

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

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

T.1.9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE - (ITEMS 13818, 13842, 13847, 13848 AND 13857)

Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

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

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

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

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

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

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

T.1.10. MANAGEMENT AND PROCEDURES IN INTENSIVE CARE UNIT - (ITEMS 13870, 13873, 13876)

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

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

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

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

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

T.1.11. CYTOTOXIC CHEMOTHERAPY ADMINISTRATION - (ITEM 13915)

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

T.1.12. IMPLANTED PUMP OR RESERVOIR/DRUG DELIVERY DEVICE - (ITEMS 13939 AND 13942)

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

T.1.13. PUVA OR UVB THERAPY - (ITEMS 14050 AND 14053)

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

T.1.14. LASER PHOTOCOAGULATION - (ITEMS 14106 TO 14124)

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

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

T.1.15. LASER PHOTOCOAGULATION (ITEM 14124)

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

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

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

Applications for approval should be addressed to:

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.1.16. 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.

T.1.17. HORMONE AND LIVING TISSUE IMPLANTATION - (ITEMS 14203 AND 14206)

Items 14203 and 14206 are not payable for artificial insemination.

T.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.

T.1.19. IMMUNOMODULATING AGENT - (ITEM 14245)

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

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

T.1.20. 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.

T.1.21. TELEHEALTH SPECIALIST SERVICES

These notes provide information on the introduction of new telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation will involve a single specialist, consultant physician or psychiatrist attending to the patient, with the possible support of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end during the service should be made in consultation with the referring practitioner.

New items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 will allow a range of existing MBS attendance items to be provided via video conferencing. These items will have a derived fee and when billed with an associated item (such as 104) a further 50% will be added to the fee. For example, item 104 + item 99 = $123.35. A patient rebate of 85% for the derived fee is payable.

Clinical indications
The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. Advice from the referring practitioner may assist in this decision. Practitioners will also need to consider whether undertaking the service and recommending a course of treatment requires the patient to be physically examined, and if so, whether this examination can be conducted via video conferencing. Some practitioners may require clinical support at the patient-end and may require the patient to be accompanied during the consultation by either the referring medical practitioner, nurse practitioner, midwife, or by a practice nurse or Aboriginal health worker providing the service on behalf of a medical practitioner. Medicare items are available for these patient-end support services where clinically relevant.

Restrictions
The new MBS telehealth attendance items are not payable for services to an admitted hospital patient. Benefits are not payable for telephone or email consultations . There must be a visual and audio link between the patient and the specialist or consultant physician in order to bill the new items. If the specialist, consultant physician or psychiatrist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth items is not payable.

Billing Requirements
All video consultations provided by specialists, consultant physicians or psychiatrists are to be **separately billed**. That is, only the relevant telehealth MBS derived item and the associated consultation item are to be itemised on the account/bill. Any other service/item billed during the same patient episode should be itemised on a separate invoice. This will ensure the claim is not rejected by Medicare Australia. There are no special billing requirements for patient end services.

Eligible Geographical Areas
A specialist, consultant physician or psychiatrist can be located anywhere throughout Australia but the location of the patient at the time of the consultation must be in a remote, regional or an outer metropolitan area. This means that all areas outside inner metropolitan are eligible locations for patient services.

The exception to this rule is for residents of a residential aged care service or patients receiving a service from an Aboriginal Medical Service or Aboriginal Community Controlled Health Service to which a direction under s.19(2) of the *Health Insurance Act 1973* applies.. These patients can receive a specialist video consultation anywhere in Australia as the inner metropolitan exclusion does not apply to these patients.

Static maps of Eligible Geographical Areas are available at www.mbsonline.gov.au/telehealth Dynamic maps are also available to search exact street locations at www.doctorconnect.gov.au

Record Keeping
Participating telehealth practitioners are required to keep contemporaneous notes of the consultation and this includes documenting that the service was performed by video conference, including the 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)
ART and Obstetric 'enabled' items 13290 and 16401, 16404, 16406, 16500, 16590, 16591 have existing EMSN caps. The telehealth items 13210, 16399 have also been capped to maintain consistency with the existing Government policy.

Aftercare Rule
For telehealth attendances, participating telehealth practitioners will be subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day
A patient may receive a telehealth consultation and a face to face consultation by the same or different provider on the same day.

Medicare benefits are not payable for a group telehealth consultation. The legislation applying to video consultations requires an attendance by a medical practitioner on a single patient on a single occasion. It is possible to provide consultations to multiple patients consecutively during a single video link, but these would need to be separate consultations.

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 that for conventional face-to-face consultations. No special documentation is required.

Technical requirements
In order to bill for a MBS telehealth consultation item a visual and audio link with the patient must be established. The government is not otherwise prescribing technical requirements and can not recommend one IT system over another. You should discuss with your professional College to see if there are any requirements/recommendations they have regarding appropriate equipment for telehealth consultations in your particular specialty.

Incentive payments
A range of financial incentives will be introduced from 1 July 2011 to encourage and support the provision of telehealth services. A telehealth bulk billing incentive is also applicable to these items. See Program Guidelines: MBS Items and Financial Incentives for Telehealth at www.mbsonline.gov.au/telehealth

Billing methods
Billing arrangements are flexible and can be negotiated between specialists and patients, or between specialists and patient-end facilities. MBS telepsychiatry has been operating for several years and psychiatrists generally either bulk bill their patients or arrange credit card payments at the time of service. Patient-end practitioners can bill as they normally would a face-to-face consultation. For electronic bulk bill claiming, at the time of the consultation, you can seek 'verbal' consent from the patient to assign the benefit to you. You can then lodge the bulk bill claim directly to Medicare on behalf of the patient. A copy of the signed assignment of benefit form must be forwarded to the patient for their records.

Training
Information about training for video consultations is available at www.mbsonline.gov.au/telehealth from some medical colleges and associations, and via professional organisation websites.

T.2.1. RADIATION ONCOLOGY - GENERAL

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

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

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

T.2.2. BRACHYTHERAPY OF THE PROSTATE - (ITEM 15338)

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

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

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

T.2.3. PLANNING SERVICES - (ITEMS 15500 TO 15562 AND 15850)

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

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

Items 15500 to 15533 (inclusive) are for a planning episode for 2D conformal radiotherapy. Items 15550 to 15562 (inclusive) are for a planning episode for 3D conformal radiotherapy.

It is expected that the 2D simulation items (15500, 15503, and 15506) would be used in association with the 2D planning items (15518, 15521, and 15524) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode.

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

T.2.4. TREATMENT VERIFICATION - (ITEMS 15700 TO 15705, 15710 AND 15800)

In these items, ‘treatment verification’ means:
a quality assurance procedure designed to facilitate accurate and reproducible delivery of the radiotherapy/brachytherapy to the prescribed site(s) or region(s) of the body as defined in the treatment prescription and/or associated dose plan(s) and which utilises the capture and assessment of appropriate images using:

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

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

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

fields. It can be itemised where single projections are acquired for multiple sites, eg multiple metastases for palliative patients. Item 15705 can be itemized only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

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

Items 15700, 15705 and 15710:

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

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

T.3.1. THERAPEUTIC DOSE OF YTTRIUM 90 - (ITEM 16003)

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

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

T.4.1. ANTENATAL SERVICE PROVIDED BY A NURSE, MIDWIFE OR A REGISTERED ABORIGINAL HEALTH WORKER - (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 registered Aboriginal Health Worker on behalf of the medical practitioner at, or from an eligible practice location in a regional, rural or remote area.

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

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

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

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

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

A registered Aboriginal Health Worker means an Aboriginal Health Worker who holds current registration 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. This includes a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973*. The Aboriginal Health Worker must have appropriate training and skills to provide an antenatal service.

The midwife, nurse or registered Aboriginal Health Worker 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 registered Aboriginal Health Worker 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 registered Aboriginal Health Worker. It is up to the medical practitioner to decide whether they need to see the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but item 16400 cannot be claimed in these circumstances.

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

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

Item 16400 can only be claimed 10 times per pregnancy.

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

T.4.2. ITEMS FOR INITIAL AND SUBSEQUENT OBSTETRIC ATTENDANCES (ITEMS 16401 AND 16404)

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

T.4.3. ANTENATAL CARE - (ITEM 16500)

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

(a) Items 16501, 16502, 16504, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514 and 16600 to 16636.
(b) The initial consultation at which pregnancy is diagnosed.
(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
(e) Treatment of an intercurrent condition not directly related to the pregnancy.

Item 16504 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

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

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

Contraindications for this item are as follows:

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

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

Benefits for management of labour and delivery covered by Items 16515, 16518, 16519 and 16525 includes the following (where indicated):-

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

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

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

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

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

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

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

T.4.6. CAESAREAN SECTION - (ITEM 16520)

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

T.4.7. COMPLICATED CONFINEMENT - (ITEM 16522)

Conditions that pose a significant risk of maternal death referred to in Item 16522 include:

- severe pre-eclampsia as defined in the Consensus Statement on the Management of Hypertension in Pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
- cardiac disease (co-managed with a consultant physician or a specialist physician);
- coagulopathy;
- severe autoimmune disease;
- previous organ transplant; or
- pre-existing renal or hepatic failure.

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

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

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

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

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

T.4.10. POST-PARTUM CARE - (ITEMS 16564 TO 16573)

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

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

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

(iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery;

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

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

Normal postnatal care by a medical practitioner would include:-

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

(ii) advice and support for establishment of breast feeding

(iii) psychological assessment and support

(iv) Rhesus status

(v) Rubella status and immunisation

(vi) contraception advice/management

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

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

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

For Items 16600 to 16636, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.

Item 51312 provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, 16627 and 16633.

T.4.12. TELEHEALTH SPECIALIST SERVICES

These notes provide information on the introduction of new telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation will involve a single specialist, consultant physician or psychiatrist attending to the patient, with the possible support of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end during the service should be made in consultation with the referring practitioner.

New items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 will allow a range of existing MBS attendance items to be provided via video conferencing. These items will have a derived fee and when billed with an associated item (such as 104) a further 50% will be added to the fee. For example, item 104 + item 99 = $123.35. A patient rebate of 85% for the derived fee is payable.

Clinical indications
The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. Advice from the referring practitioner may assist in this decision. Practitioners will also need to consider whether undertaking the service and recommending a course of treatment requires the patient to be physically examined, and if so, whether this examination can be conducted via video conferencing. Some practitioners may require clinical support at the patient-end and may require the patient to be accompanied during the consultation by either the referring medical practitioner, nurse practitioner, midwife, or by a practice nurse or Aboriginal health worker providing the service on behalf of a medical practitioner. Medicare items are available for these patient-end support services where clinically relevant.

Restrictions
The new MBS telehealth attendance items are not payable for services to an admitted hospital patient. Benefits are not payable for telephone or email consultations . There must be a visual and audio link between the patient and the specialist or consultant physician in order to bill the new items. If the specialist, consultant physician or psychiatrist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth items is not payable.

Billing Requirements
All video consultations provided by specialists, consultant physicians or psychiatrists are to be **separately billed**. That is, only the relevant telehealth MBS derived item and the associated consultation item are to be itemised on the account/bill. Any other service/item billed during the same patient episode should be itemised on a separate invoice. This will ensure the claim is not rejected by Medicare Australia. There are non special billing requirements for patient end services.

Eligible Geographical Areas
A specialist, consultant physician or psychiatrist can be located anywhere throughout Australia but the location of the patient at the time of the consultation must be in a remote, regional or an outer metropolitan area. This means that all areas outside inner metropolitan are eligible locations for patient services.

The exception to this rule is for residents of a residential aged care service or patients receiving a service from an Aboriginal Medical Service or Aboriginal Community Control Health Service to which a direction under s. 19(2) of the *Health Insurance Act 1973* applies.. These patients can receive a specialist video consultation anywhere in Australia as the inner metropolitan exclusion does not apply to these patients.

Static maps of Eligible Geographical Areas are available at www.mbsonline.gov.au/telehealth Dynamic maps are also available to search exact street locations at www.doctorconnect.gov.au

Record Keeping
Participating telehealth practitioners are required to keep contemporaneous notes and this includes documenting evidence of video-consultations. 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)
ART and Obstetric 'enabled' items 13290 and 16401, 16404, 16406, 16500, 16590, 16591 have existing EMSN caps. The telehealth items 13210, 16399 have also been capped to maintain consistency with the existing Government policy.

Aftercare Rule
For telehealth attendances, participating telehealth practitioners will be subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day
A patient may receive a telehealth consultation and a face to face consultation by the same or different provider on the same day.

Medicare benefits are not payable for a group telehealth consultation. The legislation applying to video consultations requires an attendance by a medical practitioner on a single patient on a single occasion. It is possible to provide consultations to multiple patients consecutively during a single video link, but these would need to be separate consultations.

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 that for conventional face-to-face consultations. No special documentation is required.

Technical requirements
In order to bill for a MBS telehealth consultation item a visual and audio link with the patient must be established. The government is not otherwise prescribing technical requirements and can not recommend one IT system over another. You should discuss with your professional College to see if there are any requirements/recommendations they have regarding appropriate equipment for telehealth consultations in your particular specialty.

Incentive payments
A range of financial incentives will be introduced from 1 July 2011 to encourage and support the provision of telehealth services. A telehealth bulk billing incentive is also applicable to these items. See Program Guidelines: MBS Items and Financial Incentives for Telehealth at www.mbsonline.gov.au/telehealth

Billing methods
Billing arrangements are flexible and can be negotiated between specialists and patients, or between specialists and patient-end facilities. MBS telepsychiatry has been operating for several years and psychiatrists generally either bulk bill their patients or arrange credit card payments at the time of service. Patient-end practitioners can bill as they normally would a face-to-face consultation. For electronic bulk bill claiming, at the time of the consultation, you can seek 'verbal' consent from the patient to assign the benefit to you. You can then lodge the bulk bill claim directly to Medicare on behalf of the patient. A copy of the signed assignment of benefit form must be forwarded to the patient for their records.

Training
Information about training for video consultations is available at www.mbsonline.gov.au/telehealth from some medical colleges and associations, and via professional organisation websites.

T.6.1. PRE-ANAESTHESIA CONSULTATIONS BY AN ANAESTHETIST - (ITEMS 17610 TO 17625)

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

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

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

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

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

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

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

(iv) Item 17625 (more than 45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and item 17620 and of more than 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations as well as discussion of the patient's medical condition and/or anaesthesia plan of management with other relevant healthcare professionals. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

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

- Bowel resection
- Caesarean section
- Neonatal surgery
- Major laparotomies
- Radical cancer resection
- Major reconstructive surgery eg free flap transfers, breast reconstruction
- major joint arthroplasty
- joint reconstruction
- Thoracotomy
- Craniotomy
- Spinal surgery eg spinal fusion, discectomy
- Major vascular surgery eg aortic aneurysm repair, arterial bypass surgery, carotid artery endarterectomy

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

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

NOTE I:

It is important to note that:

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

NOTE II:

- Consultation services covered by pain specialists items in the range 2801-3000 cannot be claimed in conjunction with items 17610-17625
- The consultation time under items 17610 – 17625 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.
- The requirement of a written patient management plan in items 17615-17625 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans or Case Conference items in Group A15 of the MBS.

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

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

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

(i) Acute pain management

- Postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS)
- as an independent service eg pain control following fractured ribs requiring nerve blocks
- obstetric pain management

(ii) Perioperative management of patients

- postoperative management of cardiac, respiratory and fluid balance problems following major surgery
- vascular access procedures (other than intra-operative peripheral vascular access procedures)

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

NOTE :

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

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

T.6.3. ANAESTHETIST CONSULTATIONS - OTHER - (ITEMS 17680, 17690)

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

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

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

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

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

T.6.4. TELEHEALTH SPECIALIST SERVICES

These notes provide information on the introduction of new telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation will involve a single specialist, consultant physician or psychiatrist attending to the patient, with the possible support of another medical practitioner, a participating nurse practitioner, a participating midwife, practice nurse or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end during the service should be made in consultation with the referring practitioner.

New items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 will allow a range of existing MBS attendance items to be provided via video conferencing. These items will have a derived fee and when billed with an associated item (such as 104) a further 50% will be added to the fee. For example, item 104 + item 99 = $123.35. A patient rebate of 85% for the derived fee is payable.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. Advice from the referring practitioner may assist in this decision. Practitioners will also need to consider whether undertaking the service and recommending a course of treatment requires the patient to be physically examined, and if so, whether this examination can be conducted via video conferencing. Some practitioners may require clinical support at the patient-end and may require the patient to be accompanied during the consultation by either the referring medical practitioner, nurse practitioner, midwife, or by a practice nurse or Aboriginal health worker providing the service on behalf of a medical practitioner. Medicare items are available for these patient-end support services where clinically relevant.

Restrictions
The new MBS telehealth attendance items are not payable for services to an admitted hospital patient. Benefits are not payable for telephone or email consultations . There must be a visual and audio link between the patient and the specialist or consultant physician in order to bill the new items. If the specialist, consultant physician or psychiatrist is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth items is not payable.

Billing Requirements
All video consultations provided by specialists, consultant physicians or psychiatrists are to be **separately billed**. That is, only the relevant telehealth MBS derived item and the associated consultation item are to be itemised on the account/bill. Any other service/item billed during the same patient episode should be itemised on a separate invoice. This will ensure the claim is not rejected by Medicare Australia. There are non special billing requirements for patient end services.

Eligible Geographical Areas
A specialist, consultant physician or psychiatrist can be located anywhere throughout Australia but the location of the patient at the time of the consultation must be in a remote, regional or an outer metropolitan area. This means that all areas outside inner metropolitan are eligible locations for patient services.

The exception to this rule is for residents of a residential aged care service or patients receiving a service from an Aboriginal Medical Service or Aboriginal Community Control Health Service to which a direction under s. 19(2) of the *Health Insurance Act 1973* applies.. These patients can receive a specialist video consultation anywhere in Australia as the inner metropolitan exclusion does not apply to these patients.

Static maps of Eligible Geographical Areas are available at www.mbsonline.gov.au/telehealth Dynamic maps are also available to search exact street locations at www.doctorconnect.gov.au

Record Keeping
Participating telehealth practitioners are required to keep contemporaneous notes and this includes documenting evidence of video-consultations. 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)
ART and Obstetric 'enabled' items 13290 and 16401, 16404, 16406, 16500, 16590, 16591 have existing EMSN caps. The telehealth items 13210, 16399 have also been capped to maintain consistency with the existing Government policy.

Aftercare Rule
For telehealth attendances, participating telehealth practitioners will be subject to the same aftercare rules as practitioners providing face-to-face consultations.

Multiple attendances on the same day
A patient may receive a telehealth consultation and a face to face consultation by the same or different provider on the same day.

Medicare benefits are not payable for a group telehealth consultation. The legislation applying to video consultations requires an attendance by a medical practitioner on a single patient on a single occasion. It is possible to provide consultations to multiple patients consecutively during a single video link, but these would need to be separate consultations.

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 that for conventional face-to-face consultations. No special documentation is required.

Technical requirements
In order to bill for a MBS telehealth consultation item a visual and audio link with the patient must be established. The government is not otherwise prescribing technical requirements and can not recommend one IT system over another. You should discuss with your professional College to see if there are any requirements/recommendations they have regarding appropriate equipment for telehealth consultations in your particular specialty.

Incentive payments

A range of financial incentives will be introduced from 1 July 2011 to encourage and support the provision of telehealth services. A telehealth bulk billing incentive is also applicable to these items. See Program Guidelines: MBS Items and Financial Incentives for Telehealth at www.mbsonline.gov.au/telehealth

Billing methods
Billing arrangements are flexible and can be negotiated between specialists and patients, or between specialists and patient-end facilities. MBS telepsychiatry has been operating for several years and psychiatrists generally either bulk bill their patients or arrange credit card payments at the time of service. Patient-end practitioners can bill as they normally would a face-to-face consultation. For electronic bulk bill claiming, at the time of the consultation, you can seek 'verbal' consent from the patient to assign the benefit to you. You can then lodge the bulk bill claim directly to Medicare on behalf of the patient. A copy of the signed assignment of benefit form must be forwarded to the patient for their records.

Training
Information about training for video consultations is available at www.mbsonline.gov.au/telehealth from some medical colleges and associations, and via professional organisation websites.

T.7.1. Regional or Field Nerve Blocks - General

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

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

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

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

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

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

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

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

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

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

This items covers caudal infusion/injection.

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

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

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

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

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

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

Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used to treat the obturator nerve in patients receiving botulinum toxin injections under items 18354, 18356, or 18358 for a dynamic foot deformity.

T.8.1. SURGICAL OPERATIONS

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

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

An explanation of each of these phrases is as follows.

As an Independent Procedure

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

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

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

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

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

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

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

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

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

T.8.2. MULTIPLE OPERATION RULE

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

- 100% for the item with the greatest Schedule fee
  plus 50% for the item with the next greatest Schedule fee
  plus 25% for each other item.

Note:

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

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

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

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

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

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

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

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

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

T.8.3. Procedure Performed with Local Infiltration or Digital Block

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

T.8.4. Aftercare (Post-operative Treatment)

Definition

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

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

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

Private Patients

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

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

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

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

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

If a patient was admitted as a private patient in a public hospital, then unless the MBS item does not include aftercare, no Medicare benefits are payable for aftercare. If however, a surgeon delegates aftercare to a patient’s medical practitioner, then a Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the aftercare. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

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

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

Public Patients

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

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

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

Fractures

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

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

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

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

Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

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

T.8.5. ABANDONED SURGERY - (ITEM 30001)

Item 30001 applies where the procedure has been commenced but is then discontinued for medical reasons or for other reasons which are beyond the surgeon's control (eg equipment failure). Claims for benefits under this item should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

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

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

T.8.6. REPAIR OF WOUND - (ITEMS 30023 TO 30049)

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

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

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

T.8.7. BIOPSY FOR DIAGNOSTIC PURPOSES - (ITEMS 30071 TO 30096)

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

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

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

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

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

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

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

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

T.8.9. TREATMENT OF KERATOSES, WARTS ETC (ITEMS 30185, 30186, 30187, 30189, 30192 AND 36815)

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

Treatment of fewer than 10 solar keratoses by ablative techniques such as cryotherapy attracts benefits on an attendance basis only. Where 10 or more solar keratoses are treated by ablative techniques, benefits are payable under item 30192. Where one or more solar keratoses are treated by electrosurgical destruction, simple curettage or shave excision, benefits are payable under item 30195.

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

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

(b) benefits have been paid under item 30189, and recurrence occurs.

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

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

Ablative techniques include cryotherapy and chemical removal.

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

In items 30196 and 30197, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

For the purposes of Items 30196 to 30203 (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

For the purposes of items 30196 to 30203 (inclusive), an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

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

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

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

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

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

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

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

The MCRP Officer

PO Box 1001
Tuggeranong ACT 2901

T.8.12. SENTINAL 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. Medicare funding for these items is available for five years until November 2010, before which time MSAC will review the results of trials conducted in the intervening period.

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

For the purposes of these items, the axillary lymph node levels referred to are as follows:
- **Level I** - axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** -axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - axillary lymph nodes extending above the superior border of pectoralis minor.

T.8.13. DISSECTION OF AXILLARY LYMPH NODES - (ITEMS 30335 AND 30336)

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

Anatomically, the dissection extends from below upwards as follows:
- **Level I** - dissection of axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** – dissection of axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

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

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

T.8.15. DIAGNOSTIC LAPAROSCOPY - (ITEM 30390)

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

T.8.16. MAJOR ABDOMINAL INCISION - (ITEM 30396)

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

T.8.17. GASTROINTESTINAL ENDOSCOPIC PROCEDURES - (ITEMS 30473 TO 30481, 30484 TO 30487, 30490 TO 30494, 30680 TO 30694, 32084 TO 32095, 32103, 32104 AND 32106)

The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures
Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-
(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
(ii) 'Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting', Department Health and Ageing
(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment
Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the General Notes for Guidance).

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

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

T.8.19. Gastrectomy, Sub-total Radical - (Item 30523)

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

T.8.20. Anti reflux Operations - (Items 30527 to 30533, 31464 and 31466)

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

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

For the purposes of these items the following definitions apply:

Biopsy means the removal of solid tissue by core sampling or forceps
FNA means aspiration of cellular material from solid tissue via a small gauge needle.

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

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

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

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

T.8.22. Removal of Skin Lesions - (Items 31200 to 31355)

The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in T8.13 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31200 to 31240.

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

Items 31200 and 31245 *do not require* the specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that the specimen be sent for histological examination. Items 31255 to 31335 *require* that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for Medicare benefits purposes.

Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31205 to 31240 should be used. Malignant tumours are covered by items 31255 to 31355.

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

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

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

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

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

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

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

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

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

Items 31245 and 31250 do not cover shave excision.

T.8.23. Removal of Skin Lesion From Face - (Items 31235 to 31245, 31265 to 31278, 31310 to 31320)

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

T.8.24. Dissection of Lymph Nodes of Neck - (Items 31423 to 31438)

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

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

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

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

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

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

T.8.25. 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.

T.8.26. Subcutaneous Mastectomy - (Items 31521, 31524 and 31527)

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

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

T.8.27. Fine Needle Aspiration of Breast Lesion - (Item 31533)

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

T.8.28. Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation - (Items 31539 and 31545)

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

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

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

T.8.29. Preoperative Localisation of Breast Lesion Prior to the Use of Advanced Breast Biopsy Instrumentation - (Item 31542)

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

T.8.30. Per Anal Excision of Rectal Tumour using Stereoscopic Rectoscopy - (Items 32103, 32104 and 32106)

For the purposes of items 32103, 32104 and 32106, surgeons performing this procedure should be colorectal surgeons and have evidence of the appropriate training which are recognised by the Colorectal Surgical Society of Australasia.

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

T.8.31. Sacral Nerve Stimulation for Faecal Incontinance - (Items 32213 to 32218)

Based on a review of the available evidence, the Medical Services Advisory Committee found that sacral nerve stimulation for faecal incontinence is contraindicated in all patients under 18 years of age, and in patients 18 years of age or older who:

- are medically unfit for surgery;
- are pregnant or planning pregnancy;
- have irritable bowel syndrome;
- have congenital anorectal malformations;
- have active anal abscesses or fistulas;
- have anorectal organic bowel disease – including cancer;
- have functional effects of previous pelvic irradiation;
- have congenital or acquired malformations of the sacrum; or
- have had rectal or anal surgery within the previous 12 months.

T.8.32. ARTIFICIAL BOWEL SPHINCTER (ITEMS 32220, 32221)

The safety and effectiveness of artificial bowel sphincters has not been established in children prior to puberty.

An artificial bowel sphincter is contraindicated in:

- patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases and a scarred or fragile perineum
- patients who have had an adverse reaction to radiopaque solution
- patients who engage in receptive anal intercourse.

T.8.33. VARICOSE VEINS - (ITEMS 32500 TO 32517)

Item 32500 is restricted to a maximum of 6 treatments in a 12 month period. Where additional treatments are necessary in that period, Item 32501 applies.

In items 32500 and 32501, it is sclerosant which is being injected.

Before item 32501 can be used, it is necessary to demonstrate that truncal reflux in the long or short saphenous veins does not exist on duplex examination. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

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

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

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

In relation to endovenous laser therapy (ELT) and/or radiofrequency diathermy/ablation, the following rules apply:

From 1 May 2009, amended wording in Rule 2.44.14 of the *Health Insurance (General Medical Services Table) Regulations 2008* (GMST) represented a clarification of existing policy. It did not represent a new policy decision.

From 1 May 2009, updated wording in Rule 2.44.14 of the 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 Medicare Australia's provider information line on 132 150 to confirm Medicare Australia's requirements for correct itemisation of MBS and non-MBS services on a single invoice.
- Medicare Australia 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 Medicare Australia.
- In light of the policy clarification of GMST Rule 2.44.14, with effect from 1 May 2009, Medicare Australia will be able to track any apparent cost-shifting (of ELT and/or radiofrequency diathermy/ablation) to the MBS items detailed in GMST Rule 2.44.14 or to other MBS items.

T.8.34. ENDOVENOUS LASER THERAPY (ITEMS 32520 AND 32522)

It is recommended that the medical practitioner performing the endovenous laser therapy (ELT) 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.
ELT is recommended in cases where it is documented by duplex ultrasound that the great or small saphenous vein (or one of its major tributaries) demonstrates reflux of 0.5 seconds or longer.

T.8.35. 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). Medicare coverage is available for five years until November 2011, before which time MSAC will review the results of trials conducted in the intervening period. 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 for 18 months from the date of the procedure, as this may be subject to audit by Medicare Australia.

T.8.36. ENDOVASCULAR COILING OF INTRACRANIAL ANEURYSMS - (ITEM 35412)

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

T.8.37. ARTERIAL AND VENOUS PATCHES - (ITEMS 33545 TO 33551AND 34815)

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

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

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

T.8.38. EMBOLECTOMY OR THROMBECTOMY - (ITEM 33806)

Benefit is payable once only per extremity, regardless of the number of incisions required to access the artery or bypass graft.

T.8.39. CAROTID PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY WITH STENTING - (ITEM 35307)

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

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

T.8.40. PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION - (ITEM 35317)

Item 35317 is restricted to the use of those chemotherapeutic agents other than antibiotic or antiviral agents.

T.8.41. PERIPHERAL ARTERIAL OR VENOUS EMBOLISATION - (ITEM 35321)

Item 35321 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, endovenous laser treatment for varicose veins.

T.8.42. 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). Medicare funding for these items is available until May 2011, before which time MSAC will review the results of trials conducted in the intervening period. SIRT should not be performed in an outpatient or day patient setting to ensure patient and radiation safety requirements are met.

T.8.43. PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY - (ITEMS 38309, 38312, 38315 AND 38318)

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

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

T.8.44. COLPOSCOPIC EXAMINATION - (ITEM 35614)

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

T.8.45. HYSTEROSCOPY - (ITEM 35626)

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

T.8.46. CURETTAGE OF UTERUS UNDER GA OR MAJOR NERVE BLOCK - (ITEMS 35639 AND 35640)

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

T.8.47. NEOPLASTIC CHANGES OF THE CERVIX - (ITEMS 35644-35648)

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

T.8.48. STERILISATION OF MINORS - LEGAL REQUIREMENTS - (ITEMS 35657, 35687, 35688, 35691, 37622 AND 37623)

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

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

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

T.8.49. DEBULKING OF UTERUS - (ITEM 35658)

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

T.8.50. NEPHRECTOMY - (ITEMS 36526 AND 36527)

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

T.8.51. SACRAL NERVE STIMULATION - (ITEMS 36658, 36660, AND 36662)

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

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

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

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

T.8.52. SACRAL NERVE STIMULATION (ITEMS 36663-36668)

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

T.8.53. URETEROSCOPY - (ITEM 36803)

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

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

T.8.54. SELECTIVE CORONARY ANGIOGRAPHY - (ITEMS 38215 TO 38246)

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

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

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

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

T.8.55. TRANSURETHRAL NEEDLE ABLATION (TUNA) OF THE PROSTATE - (ITEMS 37201 AND 37202)

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

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

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

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

T.8.56. GOLD FIDUCIAL MARKERS INTO THE PROSTATE - (ITEM 37217)

Item 37217 is for the insertion of gold fiducial markers into the prostate or prostate surgical bed as markers for radiotherapy. The service can not be claimed under item 37218 or any other surgical item.
This item is introduced into the Schedule on an interim basis pending the outcome of an evaluation being undertaken by the Medical Services Advisory Committee (MSAC).
Further information on the review of this service is available from the MSAC Secretariat.

T.8.57. BRACHYTHERAPY OF THE PROSTATE - (ITEM 37220)

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

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

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

T.8.58. HIGH DOSE RATE BRACHYTHERAPY - (ITEM 37227)

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

T.8.59. RADICAL OR DEBULKING OPERATION FOR OVARIAN TUMOUR - (ITEM 35720)

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

T.8.60. TRANSCUTANEOUS SPERM RETRIEVAL - (ITEM 37605)

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

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

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

T.8.61. SURGICAL SPERM RETRIEVAL, BY OPEN APPROACH - (ITEM 37606)

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

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

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

T.8.62. CARDIAC PACEMAKER INSERTION - (ITEMS 38209, 38212, 38350, 38353 AND 38356)

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

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

T.8.63. IMPLANTABLE ECG LOOP RECORDER - (ITEM 38285)

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

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

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- *electrocardiography (ECG) (items 1170-11702);*

- *echocardiography (items 55113-55115);*
- *continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);*
- *up-right tilt table test (item 11724); and*
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

T.8.64. Transluminal Insertion of Stent or Stents - (Item 38306)

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

T.8.65. Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654)

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

T.8.66. Intravascular Extraction of Permanent Pacing Leads - (Item 38358)

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

T.8.67. Cardiac Resynchronisation Therapy - (Item 38371)

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

T.8.68. Implantable Cardioverter Defibrillator - (Items 38384 and 38387)

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

T.8.69. Cardiac and Thoracic Surgical Items - (Items 38470 to 38766)

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

T.8.70. Coronary Artery Bypass - (Items 38497 to 38504)

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

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

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

T.8.71. Re-operation via Median Sternotomy - (Item 38640)

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

T.8.72. SKULL BASE SURGERY - (ITEMS 39640 TO 39662)

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

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

T.8.73. INTRADISCAL INJECTION OF CHYMOPAPAIN - (ITEM 40336)

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

T.8.74. REMOVAL OF VENTILATING TUBE FROM EAR - (ITEM 41500)

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

T.8.75. MEATOPLASTY - (ITEM 41515)

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

T.8.76. RECONSTRUCTION OF AUDITORY CANAL - (ITEM 41524)

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

T.8.77. REMOVAL OF NASAL POLYP OR POLYPI - (ITEMS 41662, 41665 AND 41668)

Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Items 41665/41668, benefit for removal of polypi would be paid under Items 41665/41668.

T.8.78. LARYNX, DIRECT EXAMINATION - (ITEM 41846)

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

T.8.79. MICROLARYNGOSCOPY - (ITEM 41858)

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

T.8.80. IMBEDDED FOREIGN BODY - (ITEM 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

T.8.81. CORNEAL INCISIONS - (ITEM 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

T.8.82. CAPSULECTOMY OR LENSECTOMY - (ITEM 42731)

The following items would be regarded as intraocular operations, and should not be itemised with Item 42731:

42551 42554 42557 42560 42563 42566 42569 42698 42701

42702	42703	42704	42707	42716	42722	42725	42734	42740
42743	42746	42761	42764	42767	42815	42857		

This list of exclusions was developed following consultation with the Royal Australian and New Zealand College of Ophthalmologists.

T.8.83. POSTERIOR JUXTASCLERAL DEPOT INJECTION - (ITEM 42741)

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

T.8.84. CYCLODESTRUCTIVE PROCEDURES - (ITEMS 42770 AND 42771)

Item 42770 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period item 42771 should be utilised.

Claims for benefits for item 42771 should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

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

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

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.8.85. LASER TRABECULOPLASTY - (ITEMS 42782 AND 42783)

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

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

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The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.8.86. LASER IRIDOTOMY - (ITEMS 42785 AND 42786)

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

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

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

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The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.8.87. Laser Capsulotomy - (Items 42788 and 42789)

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

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

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

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The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.8.88. Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Items 42791 and 42792)

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

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

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

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The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.8.89. Division of Suture by Laser - (Item 42794)

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

T.8.90. Laser Coagulation of Corneal or Scleral Blood Vessels - (Item 42797)

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

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

T.8.91. Ophthalmic Sutures - (Item 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

T.8.92. FULL FACE CHEMICAL PEEL - (ITEMS 45019 AND 45020)

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

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

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

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.8.93. ABRASIVE THERAPY/RESURFACING - (ITEMS 45021 TO 45026)

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel®) laser therapy.

T.8.94. FOREIGN IMPLANT - (ITEM 45051)

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

T.8.95. ESCHAROTOMY - (ITEM 45054)

Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

T.8.96. LOCAL SKIN FLAP - DEFINITION

Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Items 45200, 45203 or 45206 once only.

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

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

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

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

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

T.8.97. FREE GRAFTING TO BURNS - (ITEMS 45406 TO 45418)

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

T.8.98. REVISION OF SCAR - (ITEMS 45506 TO 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31200 to 31240 should be claimed.

T.8.99. REDUCTION MAMMAPLASTY - (ITEM 45522)

Medicare benefits are not payable under item 45522 for gynaecomastia. The treatment of gynaecomastia is provided for under either item 31527 or 45585.

T.8.100. 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. When both mastopexy for breast ptosis (items 45556, 45557 and 45558) and augmentation mammaplasty are performed on the same side, benefits are only payable for one or the other procedure, not both procedures. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammaplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of Medicare Australia, in a sealed envelope marked ‘Medical-in-Confidence’.

Applications for approval should be addressed to:

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

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

T.8.101. BREAST RECONSTRUCTION, MYOCUTANEOUS FLAP - (ITEM 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be

claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165, 30168, 30171, 30174 or 30177 (lipectomy items) should not be claimed in association with item 45530 as stated in the *Health Insurance (General Medical Services Table) Regulations.*

T.8.102. Breast Prosthesis, Removal and Replacement of - (Items 45552 to 45555)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45552-45555 where the procedure is performed solely to increase breast size.

T.8.103. 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 or if augmentation mammaplasty is performed simultaneously on the same side.

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

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

Applications for approval should be addressed to:

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

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

T.8.104. Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

T.8.105. 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 pathological lipodystrophy of hips, buttocks, thighs and knees or lower legs (Barraquer-Simon's Syndrome), gynaecomastia, lymphoedema or macrodystrophia lipomatosa item 45585 applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative photographs of the whole body including laterals including the abdomen and breasts. 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'.

Photos for pre-approval of liposuction of the gynaecomastia under item 45585 should be sent to the Medicare Claims Review Panel post subcutaneous mastectomy and prior to having liposuction.

Claims for benefits under item 45586 should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the Medicare Claims Review Panel, in a sealed envelope marked 'Medical-in Confidence'.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 9822
In your Capital City

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

T.8.106. MELOPLASTY FOR CORRECTION OF FACIAL ASYMMETRY - (ITEMS 45587 AND 45588)

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

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'.

Applications for approval should be addressed to:

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

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

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

T.8.107. REDUCTION OF EYELIDS - (ITEMS 45617 AND 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits. Where there is doubt as to whether benefits would be payable, advice should be sought from a medical adviser of Medicare Australia.

T.8.108. RHINOPLASTY - (ITEMS 45638, 45639)

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

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

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

Applications for approval should be addressed to:

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

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

T.8.109. CONTOUR RESTORATION - (ITEM 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

T.8.110. VERMILIONECTOMY - (ITEM 45669)

Item 45669 covers treatment of the entire lip.

T.8.111. OSTEOTOMY OF JAW - (ITEMS 45720 TO 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

T.8.112. GENIOPLASTY - (ITEM 45761)

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

T.8.113. TUMOUR, CYST, ULCER OR SCAR - (ITEMS 45801 TO 45813)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

T.8.114. FRACTURE OF MANDIBLE OR MAXILLA - (ITEMS 45975 TO 45996)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

T.8.115. REDUCTION OF DISLOCATION OR FRACTURE

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T.8.116. REMOVAL OF MULTIPLE EXOSTOSES (ITEMS 47933 AND 47936)

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

T.8.117. LUMBAR DISCECTOMY - (ITEM 48636)

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

T.8.118. DISCECTOMY IN RELATION TO ANTERIOR INTERBODY SPINAL FUSION - (ITEMS 48660 TO 48675)

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

T.8.119. INTERNAL FIXATION - (ITEMS 48678 TO 48690)

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

T.8.120. WRIST SURGERY - (ITEMS 49200 TO 49227)

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

T.8.121. DIAGNOSTIC ARTHROSCOPY AND ARTHROSCOPIC SURGERY OF THE KNEE (ITEMS 49557 AND 49563)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

T.8.122. PAEDIATRIC PATIENTS - (ITEMS 50450 TO 50658)

For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state “with open growth plates”).

T.8.123. TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS - (ITEMS 50500 TO 50588)

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

T.8.124. NON-RESECTABLE HEPATOCELLULAR CARCINOMA DESTRUCTION OF BY OPEN OR LAPAROSCOPIC RADIOFREQUENCY ABLATION - (ITEM 50952)

A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

T.8.125. 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.

T.9.1. ASSISTANCE AT OPERATIONS - (ITEMS 51300 TO 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

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

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

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations
Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	**Multiple Operation Rule - Assistant**
Item A - $300@100%	Item A (Assist.) - $300@100%
Item B - $250@50%	Item B (No Assist.)
Item C - $200@25%	Item C (Assist.) - $200@50%
Item D - $150@25%	Item D (Assist.) - $150@25%

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

Surgeons Operating Independently
Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

T.9.2. Benefits Payable under Item 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

T.9.3. Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

T.9.4. Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word “Assist.” or a series or combination of operations identified by the word “Assist.” and assistance at a delivery involving Caesarean section.

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

T.9.5. Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)

The reference to “previous significant surgical complication” covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

T.10.1. Relative Value Guide For Anaesthetics - (Group T10)

Overview of the RVG
The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under

Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Medicare Australia website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the Medicare benefit for anaesthesia in connection with a procedure is comprised of up to three components:

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

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

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

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

plus, where appropriate

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

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

Each assistant at anaesthesia service in subgroup 26 has also been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers, as appropriate, to establish the fee for the assistant service. For example:

25200	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment , to the exclusion of all other patients Derived Fee: An amount of $97.25 (5 basic units) plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate i.e

(a) the basic units allocated to whole body perfusion under item 22060;

22060	WHOLE BODY PERFUSION, CARDIAC BYPASS, using heart-lung machine or equivalent (20 basic units) Fee: $389.00 Benefit: 75% = $291.75 85% = $330.65

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 – 24136), for example;

23033	41 MINUTES TO 45 MINUTES (3 basic units) Fee: $58.35 Benefit: 75%= $43.80 85% = $ 49.60

plus, where appropriate

(c) modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020) for example

25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient's age is up to one year or 70 years or greater (1 basic units) Fee: $19.45 Benefit: 75% $14.60 85% $16.55

T.10.2. ELIGIBLE SERVICES

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. Under the Health Insurance Regulations, an "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee**.**

T.10.3. RVG UNIT VALUES

Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- *for anaesthesia*, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- *for assistance at anaesthesia*, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- *for perfusion*, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

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

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

For services lasting between 15 minutes and two hours, the appropriate 5 minute item number should be included on accounts.

Modifying Units (25000 – 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

- **ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000)**. This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate

to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
- a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
- a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
- a patient who has renal failure requiring regular dialysis.

- **ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005)**. This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:-
  - severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
  - severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

- **ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010).** This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:

- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle."

- **Where the patient is less than 12 months or age or 70 years or greater (item 25015).**
- **For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).**
- **For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).**
- **For a perfusion service in association with *after hours emergency surgery (item 25050).**

*** NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

T.10.4. Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	*DESCRIPTION*		*SCHEDULE FEE*
RVG	**Anaesthesia Service**	**Units**	**SCHEDULE FEE (Units x $ 19.45)**
20840	Anaesthesia for resection of perforated bowel	6	$116.70
23200	Time – 4 hours 40 minutes	24	$466.80
25000	Modifier - Physical status	1	$19.45
22012	Central Venous Pressure Monitoring	3	$58.35

After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	*DESCRIPTION*	**UNITS**	*SCHEDULE FEE (Units x $19.45)*
20840	Anaesthesia for resection of perforated bowel	6	$ 116.70
23190	Time – 4 hours 40 minutes	24	$466.80
25000	Modifier - Physical status	1	$19.45
22012	Central Venous Pressure Monitoring	3	$58.35
	TOTAL UNITS	34	Schedule fee = **$661.30**
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee $661.30 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.

T.10.5. Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)

Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists (ANZCA).

Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

Facilities

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

T.10.6. ACCOUNT REQUIREMENTS

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

- **the anaesthetist's account** must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- **the assistant anaesthetist's account** must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- **the perfusionist's account** must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

T.10.7. GENERAL INFORMATION

The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.9).
It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

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

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

It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

T.10.8. Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

Items 22012 and 22014

Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

T.10.9. Assistance in the Administration of Anaesthesia

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist

Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:-
(i) the need for invasive monitoring (intravascular or transoesophageal); or
(ii) organ transplantation; or
(iii) craniofacial surgery; or
(iv) major tumour resection; or
(v) separation of conjoint twins.

T.10.10. Perfusion Services - (Items 22055 to 22075)

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

The 'Time' component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Items 22065, 22070 and 22075 may only be used in association with item 22060.

Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10. The service must be performed by a medical practitioner in order to attract Medicare benefits. The "on behalf of" provisions do not apply.

T.10.11. Anaesthesia as a Therapeutic Procedure - (Item 21965)

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

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

Applications for approval should be addressed to:

The MCRP Officer
PO Box 1001
Tuggeranong ACT 2901

T.10.12. Discontinued Procedure - (Item 21990)

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

T.10.13. Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

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

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

Applications for approval should be addressed to:

The MCRP Officer
PO Box 1001

Tuggeranong ACT 2901

T.10.14. Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

T.10.15. Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

T.10.16. Anaesthesia in Connection with an Oral and MaxillofacialI Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

T.10.17. Intra-operative Blocks for Post Operative Pain - (Items 22031 to 22050)

Benefits are only payable for intra-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22050.

T.10.18. Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

T.10.19. Intrathecal or Epidural Injection for Control of Post-operative Pain - Initial - (Item 22031)

Benefits are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Benefit is not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, benefit would be payable under items 18222 or 18225.

T.10.20. Intrathecal or Epidural Injection for Control of Post-operative Pain - Subsequent - (Item 22036)

Benefits are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Benefits are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

T.10.21. Regional or Field Nerve Blocks for Post-operative Pain - (Items 22040 - 22050)

Benefits are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

T.10.22. Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

T.10.23. Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

T.10.24. Anaesthesia for Femoral Artery Embolectomy - (Item 21274)

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

T.10.25. ANAESTHESIA FOR CARDIAC CATHETERISATION - (ITEM 21941)

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

T.10.26. ANAESTHESIA FOR 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - (ITEM 21936)

Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

T.10.27. ANAESTHESIA FOR SERVICES ON THE UPPER AND LOWER ABDOMEN - (SUBGROUPS 6 AND7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:
- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:
- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

T.10.28. ANAESTHESIA FOR MICROVASCULAR FREE TISSUE FLAP SURGERY - (ITEMS 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 AND 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

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

Benefits are not payable under item 20911 for diagnostic ureteroscopy.

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

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently two botulinum toxin agents with TGA registration (Botox and Dysport). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is registered by Medicare Australia to participate in the arrangements under Section 100 of the *National Health Act 1953* relating to the use and supply of Botulinum Toxin.

Items 18354, 18356 and 18358 for the treatment of equinus, equinovarus or equinovalgus are limited to a maximum of 4 injections per patient on any one day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

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

Botulinum Toxin, which is not supplied and administered in accordance with the arrangements under Section 100 of the *National Health Act 1953*, is not free of charge to patients. Where a charge is made for the Botulinum Toxin administered, it must be separately listed on the account and not billed to Medicare.

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

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

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

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

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

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

	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY
13015	HYPERBARIC OXYGEN THERAPY, for treatment of soft tissue radionecrosis or chronic or recurring wounds where hypoxia can be demonstrated, 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 *(See para T1.1 of explanatory notes to this Category)* **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
13020	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance *(See para T1.1 of explanatory notes to this Category)* **Fee:** $254.00 **Benefit:** 75% = $190.50 85% = $215.90
13025	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $113.55 **Benefit:** 75% = $85.20 85% = $96.55
13030	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) *(See para T1.1 of explanatory notes to this Category)* **Fee:** $160.40 **Benefit:** 75% = $120.30 85% = $136.35
	SUBGROUP 2 - DIALYSIS
13100	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $69.85 **Benefit:** 75% = $52.40 85% = $59.40
13104	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year *(See para T1.3 of explanatory notes to this Category)* **Fee:** $145.20 **Benefit:** 85% = $123.45
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $119.10 **Benefit:** 75% = $89.35 85% = $101.25
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.) **Fee:** $223.50 **Benefit:** 75% = $167.65 85% = $190.00
13110	TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.) **Fee:** $224.25 **Benefit:** 75% = $168.20 85% = $190.65
13112	PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.) **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00

	SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES
13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206, 13218 applies – being services rendered during 1 treatment cycle - INITIAL cycle in a single calendar year *(See para T1.4 of explanatory notes to this Category)* **Fee:** $3,052.75 **Benefit:** 75% = $2,289.60 85% = $2,979.05 **Extended Medicare Safety Net Cap:** $1,655.60
13201	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies – being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year *(See para T1.4 of explanatory notes to this Category)* **Fee:** $2,855.50 **Benefit:** 75% = $2,141.65 85% = $2,781.80 **Extended Medicare Safety Net Cap:** $2,403.30
13202	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle *(See para T1.4 of explanatory notes to this Category)* **Fee:** $456.85 **Benefit:** 75% = $342.65 85% = $388.35 **Extended Medicare Safety Net Cap:** $64.15
13203	OVULATION MONITORING SERVICES, for artificial insemination – including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $477.65 **Benefit:** 75% = $358.25 85% = $406.05 **Extended Medicare Safety Net Cap:** $106.85
13206	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $456.85 **Benefit:** 75% = $342.65 85% = $388.35 **Extended Medicare Safety Net Cap:** $64.15
13209	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle *(See para T1.4 of explanatory notes to this Category)* **Fee:** $83.10 **Benefit:** 75% = $62.35 85% = $70.65 **Extended Medicare Safety Net Cap:** $10.75
13210	The initiation of a professional attendance via video conference rendered by a **specialist** practising in his or her specialty to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 13209. *(See para T1.21 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee **Extended Medicare Safety Net Cap:** $5.20
13212	OOCYTE RETRIEVAL for the purposes of assisted reproductive technologies – only if rendered in conjunction with a service to which Item 13200, 13201 or 13206 applies (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $347.85 **Benefit:** 75% = $260.90 85% = $295.70 **Extended Medicare Safety Net Cap:** $69.50

13215	TRANSFER OF EMBRYOS or both ova and sperm to the female reproductive system, excluding artificial insemination – only if rendered in conjunction with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in 1 treatment cycle (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $109.05 **Benefit:** 75% = $81.80 85% = $92.70 **Extended Medicare Safety Net Cap:** $48.10
13218	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.) *(See para T1.4 of explanatory notes to this Category)* **Fee:** $778.75 **Benefit:** 75% = $584.10 85% = $705.05 **Extended Medicare Safety Net Cap:** $694.30
13221	PREPARATION OF SEMEN for the purposes of artificial insemination - only if rendered in conjunction with a service to which item 13203 applies *(See para T1.4 of explanatory notes to this Category)* **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40 **Extended Medicare Safety Net Cap:** $21.40
13251	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies *(See para T1.5 of explanatory notes to this Category)* **Fee:** $410.15 **Benefit:** 75% = $307.65 85% = $348.65 **Extended Medicare Safety Net Cap:** $106.85
13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required **Fee:** $200.45 **Benefit:** 75% = $150.35 85% = $170.40
13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.) **Fee:** $401.10 **Benefit:** 75% = $300.85 85% = $340.95
	SUBGROUP 4 - PAEDIATRIC & NEONATAL
13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate **Fee:** $55.90 **Benefit:** 75% = $41.95 85% = $47.55
13303	UMBILICAL ARTERY CATHETERISATION with or without infusion **Fee:** $82.85 **Benefit:** 75% = $62.15 85% = $70.45
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor **Fee:** $327.85 **Benefit:** 75% = $245.90 85% = $278.70
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected **Fee:** $279.55 **Benefit:** 75% = $209.70 85% = $237.65
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS **Fee:** $27.90 **Benefit:** 75% = $20.95 85% = $23.75
13318	CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) - by open exposure in a person under 12 years of age (Anaes.) **Fee:** $223.20 **Benefit:** 75% = $167.40 85% = $189.75
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) **Fee:** $223.20 **Benefit:** 75% = $167.40 85% = $189.75
	SUBGROUP 5 - CARDIOVASCULAR
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75

	SUBGROUP 6 - GASTROENTEROLOGY
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE **Fee:** $176.95 **Benefit:** 75% = $132.75 85% = $150.45
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE **Fee:** $353.95 **Benefit:** 75% = $265.50 85% = $300.90
13506	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
	SUBGROUP 8 - HAEMATOLOGY
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) **Fee:** $327.05 **Benefit:** 75% = $245.30 85% = $278.00
13703	ADMINISTRATION OF BLOOD, including collection from donor **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70
13706	ADMINISTRATION OF BLOOD or bone marrow already collected *(See para T1.6 of explanatory notes to this Category)* **Fee:** $81.80 **Benefit:** 75% = $61.35 85% = $69.55
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation *(See para T1.7 of explanatory notes to this Category)* **Fee:** $47.55 **Benefit:** 75% = $35.70 85% = $40.45
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermitten flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda **Fee:** $71.60 **Benefit:** 75% = $53.70 85% = $60.90
13760	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day. **Fee:** $748.40 **Benefit:** 75% = $561.30 85% = $674.70

	SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
13815	CENTRAL VEIN CATHETERISATION (via jugular, subclavian or femoral vein) by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.) **Fee:** $83.65 **Benefit:** 75% = $62.75 85% = $71.15
13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) *(See para T1.9 of explanatory notes to this Category)* **Fee:** $111.60 **Benefit:** 75% = $83.70 85% = $94.90
13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $73.95 **Benefit:** 75% = $55.50 85% = $62.90
13839	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $22.60 **Benefit:** 75% = $16.95 85% = $19.25
13842	INTRAARTERIAL CANNULATION for the purpose of taking multiple arterial blood samples for blood gas analysis *(See para T1.9 of explanatory notes to this Category)* **Fee:** $68.00 **Benefit:** 75% = $51.00 85% = $57.80
13847	COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day including initial and subsequent consultations and monitoring of parameters (Anaes.) *(See para T1.9 of explanatory notes to this Category)* **Fee:** $153.20 **Benefit:** 75% = $114.90 85% = $130.25
13848	COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters **Fee:** $128.60 **Benefit:** 75% = $96.45 85% = $109.35
13851	CIRCULATORY SUPPORT DEVICE, management of, on first day **Fee:** $484.45 **Benefit:** 75% = $363.35 85% = $411.80
13854	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first **Fee:** $112.70 **Benefit:** 75% = $84.55 85% = $95.80
13857	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit *(See para T1.9 of explanatory notes to this Category)* **Fee:** $143.65 **Benefit:** 75% = $107.75 85% = $122.15
	SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT
13870	***(Note: See para T1.8 of Explanatory Notes to this Category for definition of an Intensive Care Unit)*** 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 *(See para T1.8 and T1.10 of explanatory notes to this Category)* **Fee:** $355.35 **Benefit:** 75% = $266.55 85% = $302.05
13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day *(See para T1.8 and T1.10 of explanatory notes to this Category)* **Fee:** $263.60 **Benefit:** 75% = $197.70 85% = $224.10

13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter in an intensive care unit and managed by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - once only for each type of pressure on any calendar day (up to a maximum of 4 pressures) *(See para T1.8 and T1.10 of explanatory notes to this Category)* **Fee:** $75.45 **Benefit:** 75% = $56.60 85% = $64.15
13881	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATION, in an Intensive Care Unit, not in association with any anaesthetic service, by a specialist or consultant physician for the purpose of subsequent ventilatory support *(See para T1.8 and T1.10 of explanatory notes to this Category)* **Fee:** $143.65 **Benefit:** 75% = $107.75 85% = $122.15
13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day *(See para T1.8 and T1.10 of explanatory notes to this Category)* **Fee:** $113.10 **Benefit:** 75% = $84.85 85% = $96.15
13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day *(See para T1.8 and T1.10 of explanatory notes to this Category)* **Fee:** $150.80 **Benefit:** 75% = $113.10 85% = $128.20
13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day *(See para T1.8 and T1.10 of explanatory notes to this Category)* **Fee:** $75.45 **Benefit:** 75% = $56.60 85% = $64.15
	SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES
13915	CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin or for the administration of drugs used immediately prior to, or with microwave (UHF radiowave) cancer therapy alone *(See para T1.11 of explanatory notes to this Category)* **Fee:** $63.85 **Benefit:** 75% = $47.90 85% = $54.30
13918	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70
13921	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment **Fee:** $108.75 **Benefit:** 75% = $81.60 85% = $92.45
13924	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $64.05 **Benefit:** 75% = $48.05 85% = $54.45
13927	CYTOTOXIC CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day **Fee:** $82.85 **Benefit:** 75% = $62.15 85% = $70.45
13930	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $115.60 **Benefit:** 75% = $86.70 85% = $98.30
13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $128.25 **Benefit:** 75% = $96.20 85% = $109.05
13936	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05

13939	IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.12 of explanatory notes to this Category)* **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70
13942	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies *(See para T1.12 of explanatory notes to this Category)* **Fee:** $64.05 **Benefit:** 75% = $48.05 85% = $54.45
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80
13948	CYTOTOXIC AGENT, instillation of, into a body cavity **Fee:** $64.05 **Benefit:** 75% = $48.05 85% = $54.45
	SUBGROUP 12 - DERMATOLOGY
14050	PUVA THERAPY or UVB THERAPY administered in whole body cabinet, not being a service associated with a service to which item 14053 applies including associated consultations other than an initial consultation *(See para T1.13 of explanatory notes to this Category)* **Fee:** $51.75 **Benefit:** 75% = $38.85 85% = $44.00
14053	PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation *(See para T1.13 of explanatory notes to this Category)* **Fee:** $51.75 **Benefit:** 75% = $38.85 85% = $44.00
14100	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of vascular lesions of the head or neck where abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period (Anaes.) **Fee:** $149.65 **Benefit:** 75% = $112.25 85% = $127.25
14106	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), where the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm^2 (Anaes.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $149.65 **Benefit:** 75% = $112.25 85% = $127.25
14109	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm^2 and up to 100cm^2 (Anaes.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $183.85 **Benefit:** 75% = $137.90 85% = $156.30
14112	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm^2 and up to 150cm^2 (Anaes.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $217.60 **Benefit:** 75% = $163.20 85% = $185.00
14115	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm^2 and up to 250cm^2 (Anaes.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $251.70 **Benefit:** 75% = $188.80 85% = $213.95

14118	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas of infancy, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 250cm^2 (Anaes.) *(See para T1.14 of explanatory notes to this Category)* **Fee:** $319.70 **Benefit:** 75% = $239.80 85% = $271.75
14124	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of haemangiomas of infancy, including any associated consultation - ***where a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** (Anaes.) *(See para T1.14 and T1.15 of explanatory notes to this Category)* **Fee:** $149.65 **Benefit:** 75% = $112.25 85% = $127.25
	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES
14200	GASTRIC LAVAGE in the treatment of ingested poison **Fee:** $58.70 **Benefit:** 75% = $44.05 85% = $49.90
14201	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient *(See para T1.16 of explanatory notes to this Category)* **Fee:** $232.45 **Benefit:** 75% = $174.35 85% = $197.60 **Extended Medicare Safety Net Cap:** $35.40
14202	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 *(See para T1.16 of explanatory notes to this Category)* **Fee:** $117.65 **Benefit:** 75% = $88.25 85% = $100.05 **Extended Medicare Safety Net Cap:** $17.95
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.) *(See para T1.17 of explanatory notes to this Category)* **Fee:** $50.20 **Benefit:** 75% = $37.65 85% = $42.70
14206	HORMONE OR LIVING TISSUE IMPLANTATION by cannula *(See para T1.17 of explanatory notes to this Category)* **Fee:** $34.95 **Benefit:** 75% = $26.25 85% = $29.75
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent **Fee:** $87.05 **Benefit:** 75% = $65.30 85% = $74.00
14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.) **Fee:** $181.85 **Benefit:** 75% = $136.40 85% = $154.60
14215	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70
14218	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies **Fee:** $51.50 **Benefit:** 75% = $38.65 85% = $43.80
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.) **Fee:** $69.05 **Benefit:** 75% = $51.80 85% = $58.70
14227	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity *(See para T1.18 of explanatory notes to this Category)* **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70

MISCELLANEOUS	OTHER
14230	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Anaes.) (Assist.) *(See para T1.18 of explanatory notes to this Category)* **Fee:** $292.50 **Benefit:** 75% = $219.40
14233	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) *(See para T1.18 of explanatory notes to this Category)* **Fee:** $355.15 **Benefit:** 75% = $266.40
14236	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.) *(See para T1.18 of explanatory notes to this Category)* **Fee:** $647.65 **Benefit:** 75% = $485.75
14239	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.) *(See para T1.18 of explanatory notes to this Category)* **Fee:** $156.45 **Benefit:** 75% = $117.35
14242	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.) *(See para T1.18 of explanatory notes to this Category)* **Fee:** $464.80 **Benefit:** 75% = $348.60
14245	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme *(See para T1.19 of explanatory notes to this Category)* **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70

	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 1 - SUPERFICIAL
15000	*(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 **Fee:** $41.75 **Benefit:** 75% = $31.35 85% = $35.50
15003	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $16.80
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field **Fee:** $92.60 **Benefit:** 75% = $69.45 85% = $78.75
15009	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15006 plus for each field in excess of 1, an amount of $18.20
15012	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye **Fee:** $52.45 **Benefit:** 75% = $39.35 85% = $44.60
	SUBGROUP 2 - ORTHOVOLTAGE
15100	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field **Fee:** $46.80 **Benefit:** 75% = $35.10 85% = $39.80
15103	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15100 plus for each field in excess of 1, an amount of $18.45
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $55.25 **Benefit:** 75% = $41.45 85% = $47.00
15109	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15106 plus for each field in excess of 1, an amount of $22.30
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field **Fee:** $118.00 **Benefit:** 75% = $88.50 85% = $100.30
15115	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15112 plus for each field in excess of 1, an amount of $46.40
	SUBGROUP 3 - MEGAVOLTAGE
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field **Fee:** $53.70 **Benefit:** 75% = $40.30 85% = $45.65
15214	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15211 plus for each field in excess of 1, an amount of $31.30
15215	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15218	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80

15221	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15224	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221 **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15227	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15230	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15215 plus for each field in excess of 1, an amount of $37.25
15233	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15218 plus for each field in excess of 1, an amount of $37.25
15236	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15221 plus for each field in excess of 1, an amount of $37.25
15239	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236 **Derived Fee:** The fee for item 15224 plus for each field in excess of 1, an amount of $37.25
15242	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15227 plus for each field in excess of 1, an amount of $37.25
15245	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15248	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15251	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15254	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251 **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15257	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $58.55 **Benefit:** 75% = $43.95 85% = $49.80
15260	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15245 plus for each field in excess of 1, an amount of $37.25

15263	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15248 plus for each field in excess of 1, an amount of $37.25
15266	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15251 plus for each field in excess of 1, an amount of $37.25
15269	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266 **Derived Fee:** The fee for item 15254 plus for each field in excess of 1, an amount of $37.25
15272	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15257 plus for each field in excess of 1, an amount of $37.25
	SUBGROUP 4 - BRACHYTHERAPY
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $350.35 **Benefit:** 75% = $262.80 85% = $297.80
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $350.35 **Benefit:** 75% = $262.80 85% = $297.80
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $664.20 **Benefit:** 75% = $498.15 85% = $590.50
15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $664.20 **Benefit:** 75% = $498.15 85% = $590.50
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $327.00 **Benefit:** 75% = $245.25 85% = $277.95
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $324.65 **Benefit:** 75% = $243.50 85% = $276.00
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $642.05 **Benefit:** 75% = $481.55 85% = $568.35
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $642.05 **Benefit:** 75% = $481.55 85% = $568.35
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) **Fee:** $708.55 **Benefit:** 75% = $531.45 85% = $634.85

15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) **Fee:** $708.55 **Benefit:** 75% = $531.45 85% = $634.85
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $770.80 **Benefit:** 75% = $578.10 85% = $697.10
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $770.80 **Benefit:** 75% = $578.10 85% = $697.10
15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $731.90 **Benefit:** 75% = $548.95 85% = $658.20
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $731.90 **Benefit:** 75% = $548.95 85% = $658.20
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.) **Fee:** $664.20 **Benefit:** 75% = $498.15 85% = $590.50
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.) **Fee:** $664.20 **Benefit:** 75% = $498.15 85% = $590.50
15338	PROSTATE, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist. *(See para T2.2 of explanatory notes to this Category)* **Fee:** $918.15 **Benefit:** 75% = $688.65 85% = $844.45
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) **Fee:** $74.80 **Benefit:** 75% = $56.10 85% = $63.60
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 **Fee:** $186.75 **Benefit:** 75% = $140.10 85% = $158.75
15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites **Fee:** $498.35 **Benefit:** 75% = $373.80 85% = $424.65
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance **Fee:** $57.30 **Benefit:** 75% = $43.00 85% = $48.75
15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface **Fee:** $114.45 **Benefit:** 75% = $85.85 85% = $97.30
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $138.85 **Benefit:** 75% = $104.15 85% = $118.05
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance **Fee:** $39.30 **Benefit:** 75% = $29.50 85% = $33.45

	SUBGROUP 5 - COMPUTERISED PLANNING
	RADIOTHERAPY PLANNING
15500	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $238.15 **Benefit:** 75% = $178.65 85% = $202.45
15503	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $305.75 **Benefit:** 75% = $229.35 85% = $259.90
15506	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $456.60 **Benefit:** 75% = $342.45 85% = $388.15
15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $206.40 **Benefit:** 75% = $154.80 85% = $175.45
15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $266.05 **Benefit:** 75% = $199.55 85% = $226.15
15513	RADIATION SOURCE LOCALISATION using a simulator or x-ray machine or CT of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338 **Fee:** $300.85 **Benefit:** 75% = $225.65 85% = $255.75
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) *(See para T2.3 of explanatory notes to this Category)* **Fee:** $385.20 **Benefit:** 75% = $288.90 85% = $327.45
15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.3 of explanatory notes to this Category)* **Fee:** $75.55 **Benefit:** 75% = $56.70 85% = $64.25
15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.3 of explanatory notes to this Category)* **Fee:** $333.55 **Benefit:** 75% = $250.20 85% = $283.55
15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.3 of explanatory notes to this Category)* **Fee:** $625.45 **Benefit:** 75% = $469.10 85% = $551.75
15527	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.3 of explanatory notes to this Category)* **Fee:** $77.50 **Benefit:** 75% = $58.15 85% = $65.90
15530	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.3 of explanatory notes to this Category)* **Fee:** $345.60 **Benefit:** 75% = $259.20 85% = $293.80

15533	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields *(See para T2.3 of explanatory notes to this Category)* **Fee:** $655.25 **Benefit:** 75% = $491.45 85% = $581.55
15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry *(See para T2.3 of explanatory notes to this Category)* **Fee:** $261.90 **Benefit:** 75% = $196.45 85% = $222.65
15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338 **Fee:** $615.60 **Benefit:** 75% = $461.70 85% = $541.90
15550	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY without 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 *(See para T2.3 of explanatory notes to this Category)* **Fee:** $646.30 **Benefit:** 75% = $484.75 85% = $572.60
15553	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 *(See para T2.3 of explanatory notes to this Category)* **Fee:** $697.30 **Benefit:** 75% = $523.00 85% = $623.60
15556	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 *(See para T2.3 of explanatory notes to this Category)* **Fee:** $652.00 **Benefit:** 75% = $489.00 85% = $578.30
15559	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. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.3 of explanatory notes to this Category)* **Fee:** $850.40 **Benefit:** 75% = $637.80 85% = $776.70

15562	DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where: (a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and (i) two planning target volumes; or (ii) two organ at risk dose goals or constraints defined in the prescription. or (c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription; or (d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity. All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images *(See para T2.3 of explanatory notes to this Category)* **Fee:** $1,099.85 **Benefit:** 75% = $824.90 85% = $1,026.15
	SUBGROUP 6 - STEREOTACTIC RADIOSURGERY
15600	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment **Fee:** $1,670.55 **Benefit:** 75% = $1,252.95 85% = $1,596.85
	SUBGROUP 7 - RADIATION ONCOLOGY TREATMENT VERIFICATION
15700	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) – when prescribed and reviewed by a radiation oncologist and not associated with item 15705 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance). *(See para T2.4 of explanatory notes to this Category)* **Fee:** $45.95 **Benefit:** 75% = $34.50 85% = $39.10
15705	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance). *(See para T2.4 of explanatory notes to this Category)* **Fee:** $76.60 **Benefit:** 75% = $57.45 85% = $65.15
15710	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 – each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance). (see para T2.5 of explanatory notes to this Category) **Fee:** $76.60 **Benefit:** 75% = $57.45 85% = $65.15
	SUBGROUP 8 - BRACHYTHERAPY PLANNING AND VERIFICATION
15800	BRACHYTHERAPY TREATMENT VERIFICATION – maximum of one only for each attendance. *(See para T2.4 of explanatory notes to this Category)* **Fee:** $96.30 **Benefit:** 75% = $72.25 85% = $81.90
15850	RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies. **Fee:** $199.50 **Benefit:** 75% = $149.65 85% = $169.60

	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE
16003	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.) *(See para T3.1 of explanatory notes to this Category)* **Fee:** $638.35 **Benefit:** 75% = $478.80 85% = $564.65
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique **Fee:** $490.55 **Benefit:** 75% = $367.95 85% = $417.00
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique **Fee:** $334.80 **Benefit:** 75% = $251.10 85% = $284.60
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 **Fee:** $289.65 **Benefit:** 75% = $217.25 85% = $246.25
16015	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain **Fee:** $4,009.50 **Benefit:** 75% = $3,007.15 85% = $3,935.80
16018	ADMINISTRATION OF ^{153} SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain. **Fee:** $2,396.90 **Benefit:** 75% = $1,797.70 85% = $2,323.20

	GROUP T4 - OBSTETRICS
16399	The initiation of a professional attendance via video conference rendered by a **specialist practising in the specialty of obstetrics** to a patient who is a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient being a service associated with item 16401, 16404, 16406, 16500, 16590 or 16591. *(See para T4.12 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee **Extended Medicare Safety Net Cap:** $23.80
16400	**ANTENATAL CARE** Antenatal service provided by a midwife, nurse or a registered Aboriginal Health Worker if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area RRMA 3-7; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy *(See para T4.1 of explanatory notes to this Category)* **Fee:** $26.75 **Benefit:** 85% = $22.75 **Extended Medicare Safety Net Cap:** $10.90
16401	OBSTETRIC SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each INITIAL attendance, in a single course of treatment - not being a service to which item 104 applies. **Fee:** $83.95 **Benefit:** 75% = $63.00 85% = $71.40 **Extended Medicare Safety Net Cap:** $54.25
16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment. **Fee:** $42.20 **Benefit:** 75% = $31.65 85% = $35.90 **Extended Medicare Safety Net Cap:** $32.55
16406	32-36 WEEK OBSTETRIC VISIT Antenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient's pregnancy when the patient is referred by a participating midwife. Payable only once for a pregnancy. **Fee:** $131.45 **Benefit:** 75% = $98.60 85% = $111.75 **Extended Medicare Safety Net Cap:** $106.85
16500	ANTENATAL ATTENDANCE *(See para T4.3 of explanatory notes to this Category)* **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Extended Medicare Safety Net Cap:** $32.55
16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy *(See para T4.4 of explanatory notes to this Category)* **Fee:** $137.95 **Benefit:** 75% = $103.50 85% = $117.30 **Extended Medicare Safety Net Cap:** $65.10
16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Extended Medicare Safety Net Cap:** $21.70

16504	TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Extended Medicare Safety Net Cap:** $21.70
16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Extended Medicare Safety Net Cap:** $21.70
16508	PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Extended Medicare Safety Net Cap:** $21.70
16509	PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance **Fee:** $46.25 **Benefit:** 75% = $34.70 85% = $39.35 **Extended Medicare Safety Net Cap:** $21.70
16511	CERVIX, purse string ligation of (Anaes.) **Fee:** $215.85 **Benefit:** 75% = $161.90 85% = $183.50 **Extended Medicare Safety Net Cap:** $108.45
16512	CERVIX, removal of purse string ligature of (Anaes.) **Fee:** $62.30 **Benefit:** 75% = $46.75 85% = $53.00 **Extended Medicare Safety Net Cap:** $32.55
16514	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) **Fee:** $35.95 **Benefit:** 75% = $27.00 85% = $30.60 **Extended Medicare Safety Net Cap:** $16.35
16515	**MANAGEMENT OF LABOUR AND DELIVERY** MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $442.25 **Benefit:** 75% = $331.70 85% = $375.95 **Extended Medicare Safety Net Cap:** $173.50
16518	MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $442.25 **Benefit:** 75% = $331.70 85% = $375.95 **Extended Medicare Safety Net Cap:** $173.50
16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $681.00 **Benefit:** 75% = $510.75 85% = $607.30 **Extended Medicare Safety Net Cap:** $325.25
16520	CAESAREAN SECTION and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) *(See para T4.6 of explanatory notes to this Category)* **Fee:** $795.95 **Benefit:** 75% = $597.00 85% = $722.25 **Extended Medicare Safety Net Cap:** $325.25

16522	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: - multiple pregnancy; - recurrent antepartum haemorrhage from 20 weeks gestation; - grades 2, 3 or 4 placenta praevia; - baby with a birth weight less than or equal to 2500gm; - pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring; - trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; - pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mm Hg associated with at least 1+ proteinuria on urinalysis; - prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; - fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR - conditions that pose a significant risk of maternal death. (Anaes.) *(See para T4.7 of explanatory notes to this Category)* **Fee:** $1,598.95 **Benefit:** 75% = $1,199.25 85% = $1,525.25 **Extended Medicare Safety Net Cap:** $433.70
16525	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $377.20 **Benefit:** 75% = $282.90 85% = $320.65 **Extended Medicare Safety Net Cap:** $151.85
16527	MANAGEMENT OF VAGINAL DELIVERY, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery. Payable once only for a pregnancy. (Anaes.) *(See para T4.8 of explanatory notes to this Category)* **Fee:** $442.25 **Benefit:** 75% = $331.70 85% = $375.95 **Extended Medicare Safety Net Cap:** $173.50
16528	CAESAREAN SECTION and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.) *(See para T4.8 of explanatory notes to this Category)* **Fee:** $795.95 **Benefit:** 75% = $597.00 85% = $722.25 **Extended Medicare Safety Net Cap:** $325.25
	POST-PARTUM CARE
16564	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $213.95 **Benefit:** 75% = $160.50 85% = $181.90 **Extended Medicare Safety Net Cap:** $216.85
16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $312.85 **Benefit:** 75% = $234.65 85% = $265.95 **Extended Medicare Safety Net Cap:** $216.85
16570	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $408.30 **Benefit:** 75% = $306.25 85% = $347.10 **Extended Medicare Safety Net Cap:** $216.85
16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $312.85 **Benefit:** 75% = $234.65 85% = $265.95 **Extended Medicare Safety Net Cap:** $216.85
16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)* **Fee:** $254.95 **Benefit:** 75% = $191.25 85% = $216.75 **Extended Medicare Safety Net Cap:** $216.85

16590	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery, payable once only for any pregnancy that has progressed beyond 20 weeks where the practitioner intends to undertake the delivery for a privately admitted patient, not being a service to which item 16591 applies. **Fee:** $318.05 **Benefit:** 75% = $238.55 85% = $270.35 **Extended Medicare Safety Net Cap:** $216.85
16591	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies. **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00 **Extended Medicare Safety Net Cap:** $108.45
	INTERVENTIONAL TECHNIQUES
16600	AMNIOCENTESIS, diagnostic *(See para T4.11 of explanatory notes to this Category)* **Fee:** $62.30 **Benefit:** 75% = $46.75 85% = $53.00 **Extended Medicare Safety Net Cap:** $32.55
16603	CHORIONIC VILLUS SAMPLING, by any route *(See para T4.11 of explanatory notes to this Category)* **Fee:** $119.60 **Benefit:** 75% = $89.70 85% = $101.70 **Extended Medicare Safety Net Cap:** $65.10
16606	FETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or foetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $238.70 **Benefit:** 75% = $179.05 85% = $202.90 **Extended Medicare Safety Net Cap:** $130.15
16609	FETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $486.75 **Benefit:** 75% = $365.10 85% = $413.75 **Extended Medicare Safety Net Cap:** $249.40
16612	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $382.95 **Benefit:** 75% = $287.25 85% = $325.55
16615	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.11 of explanatory notes to this Category)* **Fee:** $203.95 **Benefit:** 75% = $153.00 85% = $173.40
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated *(See para T4.11 of explanatory notes to this Category)* **Fee:** $203.95 **Benefit:** 75% = $153.00 85% = $173.40 **Extended Medicare Safety Net Cap:** $103.05
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios *(See para T4.11 of explanatory notes to this Category)* **Fee:** $203.95 **Benefit:** 75% = $153.00 85% = $173.40
16624	FETAL FLUID FILLED CAVITY, drainage of *(See para T4.11 of explanatory notes to this Category)* **Fee:** $293.50 **Benefit:** 75% = $220.15 85% = $249.50 **Extended Medicare Safety Net Cap:** $140.95
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis *(See para T4.11 of explanatory notes to this Category)* **Fee:** $597.60 **Benefit:** 75% = $448.20 85% = $523.90 **Extended Medicare Safety Net Cap:** $303.60

16633	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627 *(See para T4.11 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested **Extended Medicare Safety Net Cap:** $227.75
16636	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624 *(See para T4.11 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the first foetus for any additional foetus tested **Extended Medicare Safety Net Cap:** $86.80

GROUP T6 - ANAESTHETICS

SUBGROUP 1 - ANAESTHESIA CONSULTATIONS

17609	The initiation of a professional attendance via video conference rendered by a **specialist practising in the specialty of anaesthesia** to a patient who is a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient being a service associated with item 17610, 17615, 17620, 17625, 17640, 17645, 17650, 17655 or 17690. *(See para T6.4 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee
17610	**ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION** (Professional attendance by a medical practitioner in the practice of ANAESTHESIA) - a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system) - *AND of not more than 15 minutes s duration,* not being a service associated with a service to which items 2801 - 3000 apply *(See para T6.1 of explanatory notes to this Category)* **Fee:** $42.20 **Benefit:** 75% = $31.65 85% = $35.90
17615	- a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - *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 *(See para T6.1 of explanatory notes to this Category)* **Fee:** $83.95 **Benefit:** 75% = $63.00 85% = $71.40
17620	- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - *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 *(See para T6.1 of explanatory notes to this Category)* **Fee:** $116.30 **Benefit:** 75% = $87.25 85% = $98.90
17625	- a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems , the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes - *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply *(See para T6.1 of explanatory notes to this Category)* **Fee:** $148.10 **Benefit:** 75% = $111.10 85% = $125.90
17640	**ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)** (Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her) - a BRIEF consultation involving a short history and limited examination - *AND of not more than 15 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply *(See para T6.2 of explanatory notes to this Category)* **Fee:** $42.20 **Benefit:** 75% = $31.65 85% = $35.90

17645	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan - *AND of more than 15 minutes but not more than 30 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.2 of explanatory notes to this Category)* **Fee:** $83.95 **Benefit:** 75% = $63.00 85% = $71.40
17650	- a consultation involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan - *AND of more than 30 minutes but not more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply *(See para T6.2 of explanatory notes to this Category)* **Fee:** $116.30 **Benefit:** 75% = $87.25 85% = $98.90
17655	- a consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity, - *AND of more than 45 minutes duration,* not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.2 of explanatory notes to this Category)* **Fee:** $148.10 **Benefit:** 75% = $111.10 85% = $125.90
17680	**ANAESTHETIST, CONSULTATION, OTHER** (Professional attendance by an anaesthetist in the practice of ANAESTHESIA) - a consultation immediately prior to the institution of a major regional blockade in a patient in labour, where no previous anaesthesia consultation has occurred, not being a service associated with a service to which items 2801 – 3000 apply. *(See para T6.3 of explanatory notes to this Category)* **Fee:** $83.95 **Benefit:** 75% = $63.00 85% = $71.40
17690	- 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. *(See para T6.3 of explanatory notes to this Category)* **Fee:** $38.80 **Benefit:** 75% = $29.10 85% = $33.00

	GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion **Fee:** $87.00 **Benefit:** 75% = $65.25 85% = $73.95
18216	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.) **Fee:** $186.35 **Benefit:** 75% = $139.80 85% = $158.40
18219	INTRATHECAL or EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) **Derived Fee:** The fee for item 18216 plus $18.65 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less *(See para T7.2 of explanatory notes to this Category)* **Fee:** $36.95 **Benefit:** 75% = $27.75 85% = $31.45
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes *(See para T7.2 of explanatory notes to this Category)* **Fee:** $49.10 **Benefit:** 75% = $36.85 85% = $41.75
18226	**INTRATHECAL OR EPIDURAL INFUSION** of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner, **for a patient in labour**, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. *(See para T7.4 of explanatory notes to this Category)* **Fee:** $279.50 **Benefit:** 75% = $209.65 85% = $237.60
18227	**INTRATHECAL OR EPIDURAL INFUSION** of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, **for a patient in labour**, where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. *(See para T7.4 of explanatory notes to this Category)* **Derived Fee:** The fee for item 18226 plus $28.05 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance **Fee:** $61.35 **Benefit:** 75% = $46.05 85% = $52.15
18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.) **Fee:** $234.00 **Benefit:** 75% = $175.50 85% = $198.90
18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) *(See para T7.3 of explanatory notes to this Category)* **Fee:** $186.35 **Benefit:** 75% = $139.80 85% = $158.40
18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) **Fee:** $186.35 **Benefit:** 75% = $139.80 85% = $158.40
18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $61.35 **Benefit:** 75% = $46.05 85% = $52.15
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies *(See para T7.5 of explanatory notes to this Category)* **Fee:** $36.95 **Benefit:** 75% = $27.75 85% = $31.45
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $91.85 **Benefit:** 75% = $68.90 85% = $78.10

18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $36.95	**Benefit:** 75% = $27.75	85% = $31.45
18244	VAGUS NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
18248	PHRENIC NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $61.35	**Benefit:** 75% = $46.05	85% = $52.15
18252	CERVICAL PLEXUS, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $61.35	**Benefit:** 75% = $46.05	85% = $52.15
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $61.35	**Benefit:** 75% = $46.05	85% = $52.15
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $61.35	**Benefit:** 75% = $46.05	85% = $52.15
18264	PUDENDAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block *(See para T7.5 of explanatory notes to this Category)* **Fee:** $61.35	**Benefit:** 75% = $46.05	85% = $52.15
18268	OBTURATOR NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
18270	FEMORAL NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $61.35	**Benefit:** 75% = $46.05	85% = $52.15

18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15
18278	SCIATIC NERVE, injection of an anaesthetic agent *(See para T7.5 of explanatory notes to this Category)* **Fee:** $87.00	**Benefit:** 75% = $65.25	85% = $73.95
18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure *(See para T7.5 of explanatory notes to this Category)* **Fee:** $98.90	**Benefit:** 75% = $74.20	85% = $84.10
18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $144.90	**Benefit:** 75% = $108.70	85% = $123.20
18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $144.90	**Benefit:** 75% = $108.70	85% = $123.20
18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $144.90	**Benefit:** 75% = $108.70	85% = $123.20
18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.) **Fee:** $245.10	**Benefit:** 75% = $183.85	85% = $208.35
18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which items 18354, 18356 and 18358 applies (Anaes.) *(See para T7.5 of explanatory notes to this Category)* **Fee:** $122.50	**Benefit:** 75% = $91.90	85% = $104.15
18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.) **Fee:** $172.70	**Benefit:** 75% = $129.55	85% = $146.80
18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $147.75	**Benefit:** 75% = $110.85	85% = $125.60
18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) **Fee:** $172.70	**Benefit:** 75% = $129.55	85% = $146.80

GROUP T11 - BOTULINUM TOXIN INJECTIONS

BOTULINUM TOXIN

18350	BOTULINUM TOXIN (Botox), injection of, for hemifacial spasm in a patient 12 years of age or older, including all injections on any one day *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18351	BOTULINUM TOXIN (Dysport), injection of, for the treatment of hemifacial spasm in a patient 18 years of age or older, including all such injections on any one day *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18352	BOTULINUM TOXIN (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all injections on any one day *(See para T11.1 of explanatory notes to this Category)* **Fee:** $245.10 **Benefit:** 75% = $183.85 85% = $208.35
18354	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18356	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18358	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient, aged two years or older, in accordance with the supply of the drug under instrument PB 122 of 2008 (Arrangements — Botulinum Toxin Program) made under Section 100 (1) (b) of the *National Health Act 1953*, including all such injections on any one day for all or any of the muscles subserving one functional activity and supplied by one motor nerve - applicable only to the first two treatments of each limb of the patient on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18360	BOTULINUM TOXIN (Botox), injection of, for the treatment of focal spasticity in adults, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18361	Botulinum toxin (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy, in a patient who is at least 2 years but less than 18 years, in association with either: (a) physiotherapy or occupational therapy or both; or (b) electrical stimulation or ultrasound for muscle localisation; including all injections for any or all of the muscles sub-serving one functional activity supplied by one motor nerve — with a maximum of four treatments per patient on any one day, and with a maximum of two treatments per limb (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18362	BOTULINUM TOXIN (Botox), injection of, for the treatment of severe primary hyperhidrosis of the axillae, including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $242.10 **Benefit:** 75% = $181.60 85% = $205.80

18364	BOTULINUM TOXIN (Dysport), injection of, for treatment of spasticity of the arm in adults following a stroke, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18366	BOTULINUM TOXIN (Botox), injection of, for the treatment of strabismus in children and adults, including all such injections on any one day and associated electromyography (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $153.50 **Benefit:** 75% = $115.15 85% = $130.50
18368	BOTULINUM TOXIN (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day *(See para T11.1 of explanatory notes to this Category)* **Fee:** $262.05 **Benefit:** 75% = $196.55 85% = $222.75
18370	BOTULINUM TOXIN (Botox), injection of, for the treatment of blepharospasm in a patient 12 years of age or older, including all such injections on any one day. (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $44.20 **Benefit:** 75% = $33.15 85% = $37.60
18371	BOTULINUM TOXIN (Dysport), injection of, for the treatment of blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $44.20 **Benefit:** 75% = $33.15 85% = $37.60
18372	BOTULINUM TOXIN (Botox), injection of, for the treatment of bilateral blepharospasm in a patient 12 years of age or older, including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
18373	BOTULINUM TOXIN (Dysport), injection of, for the treatment of bilateral blepharospasm in a patient 18 years of age or older, including all such injections on any one day (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15

	GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE
	SUBGROUP 1 - HEAD
20100	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20102	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for plastic repair of cleft lip (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20104	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroconvulsive therapy (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20120	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20124	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for otoscopy (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20140	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on eye, not being a service to which another item in this Group applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20142	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lens surgery (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20143	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retinal surgery (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20144	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for corneal transplant (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20145	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vitrectomy (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20146	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of conjunctiva (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20147	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for squint repair (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20148	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ophthalmoscopy (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20160	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nose or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20162	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on the nose and accessory sinuses (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20164	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20170	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20172	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of cleft palate (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75

20174	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision of retropharyngeal tumour (9 basic units) **Fee:** $175.05 **Benefit:** 75% = $131.30 85% = $148.80
20176	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical intraoral surgery (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20190	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20192	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20210	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20212	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for subdural taps (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20214	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for burr holes of the cranium (9 basic units) **Fee:** $175.05 **Benefit:** 75% = $131.30 85% = $148.80
20216	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) **Fee:** $389.00 **Benefit:** 75% = $291.75 85% = $330.65
20220	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for spinal fluid shunt procedures (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20222	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ablation of an intracranial nerve (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20225	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all cranial bone procedures (12 basic units) **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
20230	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the head or face (12 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
	SUBGROUP 2 - NECK
20300	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20305	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20320	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20321	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20330	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laser surgery to the airway (excluding nose and mouth) (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30

20350	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20352	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for simple ligation of major vessels of neck (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20355	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the neck (12 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
	SUBGROUP 3 - THORAX
20400	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
20401	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20402	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on breast (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20403	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20404	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for mastectomy (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20405	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20406	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95
20410	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrical conversion of arrhythmias (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20420	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20440	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the sternum (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20450	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20452	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical surgery on clavicle, scapula or sternum (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20470	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20472	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoplasty (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20474	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on chest wall (13 basic units) *(See para T10.22 of explanatory notes to this Category)* **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95

20475	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior thorax (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
	SUBGROUP 4 - INTRATHORACIC
20500	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the oesophagus (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20520	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20522	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for needle biopsy of pleura (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20524	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pneumocentesis (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20526	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracoscopy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20528	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for mediastinoscopy (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20540	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units) **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95
20542	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary decortication (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20546	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pulmonary resection with thoracoplasty (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20548	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for intrathoracic repair of trauma to trachea and bronchi (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20560	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the heart, pericardium or great vessels of chest (20 basic units) **Fee:** $389.00 **Benefit:** 75% = $291.75 85% = $330.65
	SUBGROUP 5 - SPINE AND SPINAL CORD
20600	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20604	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for posterior cervical laminectomy with the patient in the sitting position (13 basic units) **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95
20620	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20622	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for thoracolumbar sympathectomy (13 basic units) **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95
20630	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20632	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar sympathectomy (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75

20634	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for chemonucleolysis (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20670	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extensive spine and/or spinal cord procedures (13 basic units) *(See para T10.23 of explanatory notes to this Category)* **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95
20680	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for manipulation of spine when performed in the operating theatre of a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
20690	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
	SUBGROUP 6 - UPPER ABDOMEN
20700	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
20702	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous liver biopsy (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20703	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures on the nerves, muscles, tendons and fascia of the upper abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20704	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior upper abdomen (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20705	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopy procedures (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20706	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laparoscopic procedures in the upper abdomen, not being a service to which another item in this Subgroup applies (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20730	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20740	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20745	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20750	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in upper abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20752	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional hernia and/or wound dehiscence (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20754	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on an omphalocele (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20756	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transabdominal repair of diaphragmatic hernia (9 basic units) **Fee:** $175.05 **Benefit:** 75% = $131.30 85% = $148.80

20770	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major upper abdominal blood vessels (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20790	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures within the peritoneal cavity in upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20791	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for gastric reduction or gastroplasty for the treatment of morbid obesity (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20792	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for partial hepatectomy (excluding liver biopsy) (13 basic units) **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95
20793	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extended or trisegmental hepatectomy (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20794	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pancreatectomy, partial or total (12 basic units) **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
20798	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the upper abdomen (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20799	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
	SUBGROUP 7 - LOWER ABDOMEN
20800	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
20802	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lipectomy of the lower abdomen (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20803	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20804	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20805	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for diagnostic laparoscopic procedures (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20806	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for laparoscopic procedures in the lower abdomen (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20810	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower intestinal endoscopic procedures (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20815	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20820	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20830	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15

20832	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20840	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for all procedures within the peritoneal cavity in lower abdomen including appendicectomy, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20841	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20842	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for amniocentesis (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20844	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20845	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical prostatectomy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20846	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical hysterectomy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20847	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for ovarian malignancy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20848	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for pelvic exenteration (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20850	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarean section (12 basic units) **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
20855	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for Caesarean hysterectomy or hysterectomy within 24 hours of delivery. (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20860	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20862	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal procedures, including upper 1/3 of ureter (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20863	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for nephrectomy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20864	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total cystectomy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20866	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for adrenalectomy (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20867	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for neuro endocrine tumour removal in the lower abdomen (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20868	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for renal transplantation (donor or recipient) (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20880	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
20882	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for inferior vena cava ligation (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35

20884	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous umbrella insertion (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20886	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
	SUBGROUP 8 - PERINEUM
20900	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the perineum (including biopsy of male genital system), not being a service to which another item in this Subgroup applies (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
20902	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for anorectal procedures (including endoscopy and/or biopsy) (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20904	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20905	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the perineum (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20906	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vulvectomy (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20910	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20911	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for endoscopic ureteroscopic surgery including laser procedures (5 basic units) *(See para T10.29 of explanatory notes to this Category)* **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20912	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of bladder tumour(s) (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20914	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transurethral resection of prostate (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20916	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bleeding post-transurethral resection (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
20920	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on male external genitalia, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20924	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on undescended testis, unilateral or bilateral (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20926	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, inguinal approach (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20928	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical orchidectomy, abdominal approach (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20930	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for orchiopexy, unilateral or bilateral (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20932	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15

20934	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20936	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20938	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for insertion of penile prosthesis (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20940	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for per vagina and vaginal procedures (including biopsy of labia, vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20942	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures including repair operations and urinary incontinence procedures (perineal) (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20943	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for transvaginal assisted reproductive services (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20944	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal hysterectomy (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
20946	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal delivery (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
20948	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for purse string ligation of cervix, or removal of purse string ligature (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20950	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for culdoscopy (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20952	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hysteroscopy (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20953	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for endometrial ablation or resection in association with hysteroscopy (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20954	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for correction of inverted uterus (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
20956	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for evacuation of retained products of conception, as a complication of confinement (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
20958	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
20960	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
	SUBGROUP 9 - PELVIS (EXCEPT HIP)
21100	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21110	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70

21112	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21114	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21116	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow harvesting from the pelvis (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21120	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the bony pelvis (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21130	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for body cast application or revision when performed in the operating theatre of a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21140	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for interpelviabdominal (hind-quarter) amputation (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
21150	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21155	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21160	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21170	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
	SUBGROUP 10 - UPPER LEG (EXCEPT KNEE)
21195	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21199	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21200	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21202	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the hip joint (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21210	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21212	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for hip disarticulation (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21214	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total hip replacement or revision (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35

21216	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral total hip replacement (14 basic units) **Fee:** $272.30 **Benefit:** 75% = $204.25 85% = $231.50
21220	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21230	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures involving upper 2/3 of femur, not being a service to which another item in this Subgroup applies (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21232	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for above knee amputation (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21234	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of the upper 2/3 of femur (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21260	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures involving veins of upper leg, including exploration (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21270	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21272	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery ligation (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21274	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for femoral artery embolectomy (6 basic units) *(See para T10.24 of explanatory notes to this Category)* **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21275	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper leg (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21280	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper leg (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
	SUBGROUP 11 - KNEE AND POPLITEAL AREA
21300	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21321	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21340	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21360	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on lower 1/3 of femur (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21380	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21382	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of knee joint (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21390	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60

21392	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21400	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21402	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for knee replacement (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
21403	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bilateral knee replacement (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21404	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for disarticulation of knee (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21420	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cast application, removal, or repair involving knee joint, undertaken in a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21430	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21432	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of arteriovenous fistula of knee or popliteal area (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21440	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21445	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the knee and/or popliteal area (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
	SUBGROUP 12 - LOWER LEG (BELOW KNEE)
21460	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21461	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21462	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on lower leg, ankle, or foot (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21464	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedure of ankle joint (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21472	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for repair of Achilles tendon (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21474	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for gastrocnemius recession (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21480	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21482	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection of bone involving lower leg, ankle or foot (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70

21484	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for osteotomy or osteoplasty of tibia or fibula (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21486	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total ankle replacement (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
21490	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lower leg cast application, removal or repair, undertaken in a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21500	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21502	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of the lower leg (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21520	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21522	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for venous thrombectomy of the lower leg (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21530	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
21532	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of toe (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21535	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the lower leg (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
	SUBGROUP 13 - SHOULDER AND AXILLA
21600	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21610	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21620	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21622	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of shoulder joint (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21630	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21632	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21634	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder disarticulation (9 basic units) **Fee:** $175.05 **Benefit:** 75% = $131.30 85% = $148.80
21636	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for interthoracoscapular (forequarter) amputation (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00

21638	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total shoulder replacement (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21650	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21652	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures for axillary-brachial aneurysm (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21654	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bypass graft of arteries of shoulder or axilla (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21656	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for axillary-femoral bypass graft (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21670	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of shoulder or axilla (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21680	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21682	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for shoulder spica application when undertaken in a hospital (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21685	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the shoulder or the axilla (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
	SUBGROUP 14 - UPPER ARM AND ELBOW
21700	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21710	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21712	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open tenotomy of the upper arm or elbow (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21714	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenoplasty of the upper arm or elbow (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21716	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for tenodesis for rupture of long tendon of biceps (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21730	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21732	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of elbow joint (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21740	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21756	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radical procedures on the upper arm or elbow (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21760	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total elbow replacement (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75

21770	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21772	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of arteries of the upper arm (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21780	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21785	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the upper arm or elbow (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21790	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of upper arm (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
	SUBGROUP 15 - FOREARM WRIST AND HAND
21800	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21810	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21820	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21830	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21832	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for total wrist replacement (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
21834	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arthroscopic procedures of the wrist joint (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21840	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21842	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for embolectomy of artery of forearm, wrist or hand (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21850	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21860	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21865	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units) *(See para T10.28 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21870	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of forearm, wrist or hand (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00

21872	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for microsurgical reimplantation of a finger (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
	SUBGROUP 16 - ANAESTHESIA FOR BURNS
21878	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21879	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting,where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21880	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
21881	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units) **Fee:** $175.05 **Benefit:** 75% = $131.30 85% = $148.80
21882	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units) **Fee:** $213.95 **Benefit:** 75% = $160.50 85% = $181.90
21883	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units) **Fee:** $252.85 **Benefit:** 75% = $189.65 85% = $214.95
21884	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
21885	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units) **Fee:** $330.65 **Benefit:** 75% = $248.00 85% = $281.10
21886	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $314.15
21887	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units) **Fee:** $408.45 **Benefit:** 75% = $306.35 85% = $347.20
	SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
21900	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for hysterosalpingography (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21906	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: lumbar or thoracic (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21908	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: cervical (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21910	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for myelography: posterior fossa (9 basic units) **Fee:** $175.05 **Benefit:** 75% = $131.30 85% = $148.80
21912	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: lumbar or thoracic (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70

21914	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for injection procedure for discography: cervical (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21915	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral arteriogram (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21916	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for arteriograms: cerebral, carotid or vertebral (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21918	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retrograde arteriogram: brachial or femoral (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21922	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
21925	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21926	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for fluoroscopy (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21927	**INITIATION OF MANAGEMENT OF ANAESTHESIA** forl barium enema or other opaque study of the small bowel (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21930	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for bronchography (6 basic units) **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21935	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for phlebography (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21936	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for heart, 2 dimensional real time transoesophageal examination (6 basic units) *(See para T10.26 of explanatory notes to this Category)* **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
21939	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for peripheral venous cannulation (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21941	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units) *(See para T10.25 of explanatory notes to this Category)* **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
21942	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21943	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21945	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21949	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for harvesting of bone marrow for the purpose of transplantation (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21952	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for muscle biopsy for malignant hyperpyrexia (10 basic units) **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
21955	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electroencephalography (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70

21959	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for brain stem evoked response audiometry (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21962	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21965	**INITIATION OF MANAGEMENT OF ANAESTHESIA** as a therapeutic procedure **where it can be demonstrated that there is a clinical need for anaesthesia, not for the treatment of headache of any etiology** (5 basic units) *(See para T10.11 of explanatory notes to this Category)* **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21969	**INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units) **Fee:** $155.60 **Benefit:** 75% = $116.70 85% = $132.30
21970	**INITIATION OF MANAGEMENT OF ANAESTHESIA** during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units) **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
21973	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for brachytherapy using radioactive sealed sources (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21976	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for therapeutic nuclear medicine (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21980	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for radiotherapy (5 basic units) **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
21981	**ANAESTHETIC AGENT ALLERGY TESTING**, using skin sensitivity methods in a patient with a history of prior anaphylactic or anaphylactoid reaction or cardiovascular collapse associated with the management of anaesthesia agents (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
	SUBGROUP 18 - MISCELLANEOUS
21990	**INITIATION OF MANAGEMENT OF ANAESTHESIA** when no procedure ensues (3 basic units) *(See para T10.12 of explanatory notes to this Category)* **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
21992	**INITIATION OF MANAGEMENT OF ANAESTHESIA** performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
21997	**INITIATION OF MANAGEMENT OF ANAESTHESIA** in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies **where it can be demonstrated that there is a clinical need for anaesthesia** (4 basic units) *(See para T10.13 of explanatory notes to this Category)* **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
	SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES
22001	**COLLECTION OF BLOOD FOR AUTOLOGOUS TRANSFUSION** or when homologous blood is required for immediate transfusion in an emergency situation, **when performed in association with the administration of anaesthesia** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
22002	**ADMINISTRATION OF BLOOD** or bone marrow already collected **when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
22007	**ENDOTRACHEAL INTUBATION** with flexible fibreoptic scope associated with difficult airway **when performed in association with the administration of anaesthesia** (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15

22008	**DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER,** insertion of when **performed in association with the administration of anaesthesia** (4 basic units) **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
22012	**BLOOD PRESSURE MONITORING** (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day, up to a maximum of 4 pressures (not being a service to which item 13876 applies) **when performed in association with the administration of anaesthesia** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
22014	**BLOOD PRESSURE MONITORING** (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - once only for each type of pressure on any calendar day, up to a maximum of 4 pressures (not being a service to which item 13876 applies) **when performed in association with the administration of anaesthesia relating to another discrete operation on the same day** (3 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
22015	**RIGHT HEART BALLOON CATHETER,** insertion of, including pulmonary wedge pressure and cardiac output measurement, **when performed in association with the administration of anaesthesia** (6 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
22018	**MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM**, using measurements of parameters, including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood and incorporating serial arterial blood gas analysis and a written record of the results, when performed in association with the administration of anaesthesia, not being a service associated with a service to which item 11503 applies (7 basic units) **Fee:** $136.15 **Benefit:** 75% = $102.15 85% = $115.75
22020	**CENTRAL VEIN CATHETERISATION** (via jugular, subclavian or femoral vein) by percutaneous or open exposure, not being a service to which item 13318 applies, **when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
22025	**INTRAARTERIAL CANNULATION when performed in association with the administration of anaesthesia** (4 basic units) *(See para T10.8 of explanatory notes to this Category)* **Fee:** $77.80 **Benefit:** 75% = $58.35 85% = $66.15
22031	**INTRATHECAL or EPIDURAL INJECTION** (initial) of a therapeutic substance or substances, with or without insertion of a catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22036 applies (5 basic units) *(See para T10.19 of explanatory notes to this Category)* **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
22036	**INTRATHECAL or EPIDURAL INJECTION** (subsequent) of a therapeutic substance or substances, using an in-situ catheter, **in association with anaesthesia and surgery**, for postoperative pain management, not being a service associated with a service to which 22031 applies (3 basic units) *(See para T10.20 of explanatory notes to this Category)* **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
22040	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room theatre or recovery room for the control of post operative pain via the femoral **OR** sciatic nerves, **in conjunction with hip, knee, ankle or foot surgery** (2 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $38.90 **Benefit:** 75% = $29.20 85% = $33.10
22045	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral **AND** sciatic nerves, **in conjunction with hip, knee, ankle or foot surgery** (3 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
22050	**INTRODUCTION OF A REGIONAL OR FIELD NERVE BLOCK** peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus **in conjunction with shoulder surgery** (2 basic units) *(See para T10.17 and T10.21 of explanatory notes to this Category)* **Fee:** $38.90 **Benefit:** 75% = $29.20 85% = $33.10

22051	**INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY** - Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units) **Fee:** $175.05 **Benefit:** 75% = $131.30 85% = $148.80
22055	**PERFUSION OF LIMB OR ORGAN** using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $233.40 **Benefit:** 75% = $175.05 85% = $198.40
22060	**WHOLE BODY PERFUSION, CARDIAC BYPASS**, using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (20 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $389.00 **Benefit:** 75% = $291.75 85% = $330.65
22065	**INDUCED CONTROLLED HYPOTHERMIA** total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $97.25 **Benefit:** 75% = $72.95 85% = $82.70
22070	**CARDIOPLEGIA**, blood or crystalloid, administration by any route, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (10 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $194.50 **Benefit:** 75% = $145.90 85% = $165.35
22075	**DEEP HYPOTHERMIC CIRCULATORY ARREST**, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units) *(See para T10.10 of explanatory notes to this Category)* **Fee:** $291.75 **Benefit:** 75% = $218.85 85% = $248.00
	SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE
22900	**INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA** for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units) *(See para T10.14 of explanatory notes to this Category)* **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
22905	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for restorative dental work (6 basic units) *(See para T10.14 of explanatory notes to this Category)* **Fee:** $116.70 **Benefit:** 75% = $87.55 85% = $99.20
	SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS
23010	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 For a period of: (FIFTEEN MINUTES OR LESS) (1 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
23021	16 MINUTES TO 20 MINUTES (2 basic units) **Fee:** $38.90 **Benefit:** 75% = $29.20 85% = $33.10
23022	21 MINUTES TO 25 MINUTES (2 basic units) **Fee:** $38.90 **Benefit:** 75% = $29.20 85% = $33.10
23023	26 MINUTES TO 30 MINUTES (2 basic units) **Fee:** $38.90 **Benefit:** 75% = $29.20 85% = $33.10
23031	31 MINUTES TO 35 MINUTES (3 basic units) **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60

23032	36 MINUTES TO 40 MINUTES (3 basic units) **Fee:** $58.35	**Benefit:** 75% = $43.80	85% = $49.60
23033	41 MINUTES TO 45 MINUTES (3 basic units) **Fee:** $58.35	**Benefit:** 75% = $43.80	85% = $49.60
23041	46 MINUTES TO 50 MINUTES (4 basic units) **Fee:** $77.80	**Benefit:** 75% = $58.35	85% = $66.15
23042	51 MINUTES TO 55 MINUTES (4 basic units) **Fee:** $77.80	**Benefit:** 75% = $58.35	85% = $66.15
23043	56 MINUTES TO 1:00 HOUR (4 basic units) **Fee:** $77.80	**Benefit:** 75% = $58.35	85% = $66.15
23051	1:01 HOURS TO 1:05 HOURS (5 basic units) **Fee:** $97.25	**Benefit:** 75% = $72.95	85% = $82.70
23052	1:06 HOURS TO 1:10 HOURS (5 basic units) **Fee:** $97.25	**Benefit:** 75% = $72.95	85% = $82.70
23053	1:11 HOURS TO 1:15 HOURS (5 basic units) **Fee:** $97.25	**Benefit:** 75% = $72.95	85% = $82.70
23061	1:16 HOURS TO 1:20 HOURS (6 basic units) **Fee:** $116.70	**Benefit:** 75% = $87.55	85% = $99.20
23062	1:21 HOURS TO 1:25 HOURS (6 basic units) **Fee:** $116.70	**Benefit:** 75% = $87.55	85% = $99.20
23063	1:26 HOURS TO 1:30 HOURS (6 basic units) **Fee:** $116.70	**Benefit:** 75% = $87.55	85% = $99.20
23071	1:31 HOURS TO 1:35 HOURS (7 basic units) **Fee:** $136.15	**Benefit:** 75% = $102.15	85% = $115.75
23072	1:36 HOURS TO 1:40 HOURS (7 basic units) **Fee:** $136.15	**Benefit:** 75% = $102.15	85% = $115.75
23073	1:41 HOURS TO 1:45 HOURS (7 basic units) **Fee:** $136.15	**Benefit:** 75% = $102.15	85% = $115.75
23081	1:46 HOURS TO 1:50 HOURS (8 basic units) **Fee:** $155.60	**Benefit:** 75% = $116.70	85% = $132.30
23082	1:51 HOURS TO 1:55 HOURS (8 basic units) **Fee:** $155.60	**Benefit:** 75% = $116.70	85% = $132.30
23083	1:56 HOURS TO 2:00 HOURS (8 basic units) **Fee:** $155.60	**Benefit:** 75% = $116.70	85% = $132.30
23091	2:01 HOURS TO 2:10 HOURS (9 basic units) **Fee:** $175.05	**Benefit:** 75% = $131.30	85% = $148.80
23101	2:11 HOURS TO 2:20 HOURS (10 basic units) **Fee:** $194.50	**Benefit:** 75% = $145.90	85% = $165.35
23111	2:21 HOURS TO 2:30 HOURS (11 basic units) **Fee:** $213.95	**Benefit:** 75% = $160.50	85% = $181.90
23112	2:31 HOURS TO 2:40 HOURS (12 basic units) **Fee:** $233.40	**Benefit:** 75% = $175.05	85% = $198.40
23113	2:41 HOURS TO 2:50 HOURS (13 basic units) **Fee:** $252.85	**Benefit:** 75% = $189.65	85% = $214.95

23114	2:51 HOURS TO 3:00 HOURS (14 basic units) **Fee:** $272.30	**Benefit:** 75% = $204.25	85% = $231.50
23115	3:01 HOURS TO 3:10 HOURS (15 basic units) **Fee:** $291.75	**Benefit:** 75% = $218.85	85% = $248.00
23116	3:11 HOURS TO 3:20 HOURS (16 basic units) **Fee:** $311.20	**Benefit:** 75% = $233.40	85% = $264.55
23117	3:21 HOURS TO 3:30 HOURS (17 basic units) **Fee:** $330.65	**Benefit:** 75% = $248.00	85% = $281.10
23118	3:31 HOURS TO 3:40 HOURS (18 basic units) **Fee:** $350.10	**Benefit:** 75% = $262.60	85% = $297.60
23119	3:41 HOURS TO 3:50 HOURS (19 basic units) **Fee:** $369.55	**Benefit:** 75% = $277.20	85% = $314.15
23121	3:51 HOURS TO 4:00 HOURS (20 basic units) **Fee:** $389.00	**Benefit:** 75% = $291.75	85% = $330.65
23170	4:01 HOURS TO 4:10 HOURS (21 basic units) **Fee:** $408.45	**Benefit:** 75% = $306.35	85% = $347.20
23180	4:11 HOURS TO 4:20 HOURS (22 basic units) **Fee:** $427.90	**Benefit:** 75% = $320.95	85% = $363.75
23190	4:21 HOURS TO 4:30 HOURS (23 basic units) **Fee:** $447.35	**Benefit:** 75% = $335.55	85% = $380.25
23200	4:31 HOURS TO 4:40 HOURS (24 basic units) **Fee:** $466.80	**Benefit:** 75% = $350.10	85% = $396.80
23210	4:41 HOURS TO 4:50 HOURS (25 basic units) **Fee:** $486.25	**Benefit:** 75% = $364.70	85% = $413.35
23220	4:51 HOURS TO 5:00 HOURS (26 basic units) **Fee:** $505.70	**Benefit:** 75% = $379.30	85% = $432.00
23230	5:01 HOURS TO 5:10 HOURS (27 basic units) **Fee:** $525.15	**Benefit:** 75% = $393.90	85% = $451.45
23240	5:11 HOURS TO 5:20 HOURS (28 basic units) **Fee:** $544.60	**Benefit:** 75% = $408.45	85% = $470.90
23250	5:21 HOURS TO 5:30 HOURS (29 basic units) **Fee:** $564.05	**Benefit:** 75% = $423.05	85% = $490.35
23260	5:31 HOURS TO 5:40 HOURS (30 basic units) **Fee:** $583.50	**Benefit:** 75% = $437.65	85% = $509.80
23270	5:41 HOURS TO 5:50 HOURS (31 basic units) **Fee:** $602.95	**Benefit:** 75% = $452.25	85% = $529.25
23280	(5:51 HOURS TO 6:00 HOURS (32 basic units) **Fee:** $622.40	**Benefit:** 75% = $466.80	85% = $548.70
23290	6:01 HOURS TO 6:10 HOURS (33 basic units) **Fee:** $641.85	**Benefit:** 75% = $481.40	85% = $568.15
23300	6:11 HOURS TO 6:20 HOURS (34 basic units) **Fee:** $661.30	**Benefit:** 75% = $496.00	85% = $587.60
23310	6:21 HOURS TO 6:30 HOURS (35 basic units) **Fee:** $680.75	**Benefit:** 75% = $510.60	85% = $607.05

23320	6:31 HOURS TO 6:40 HOURS (36 basic units) **Fee:** $700.20	**Benefit:** 75% = $525.15	85% = $626.50
23330	6:41 HOURS TO 6:50 HOURS (37 basic units) **Fee:** $719.65	**Benefit:** 75% = $539.75	85% = $645.95
23340	6:51 HOURS TO 7:00 HOURS (38 basic units) **Fee:** $739.10	**Benefit:** 75% = $554.35	85% = $665.40
23350	7:01 HOURS TO 7:10 HOURS (39 basic units) **Fee:** $758.55	**Benefit:** 75% = $568.95	85% = $684.85
23360	7:11 HOURS TO 7:20 HOURS (40 basic units) **Fee:** $778.00	**Benefit:** 75% = $583.50	85% = $704.30
23370	7:21 HOURS TO 7:30 HOURS (41 basic units) **Fee:** $797.45	**Benefit:** 75% = $598.10	85% = $723.75
23380	7:31 HOURS TO 7:40 HOURS (42 basic units) **Fee:** $816.90	**Benefit:** 75% = $612.70	85% = $743.20
23390	7:41 HOURS TO 7:50 HOURS (43 basic units) **Fee:** $836.35	**Benefit:** 75% = $627.30	85% = $762.65
23400	7:51 HOURS TO 8:00 HOURS (44 basic units) **Fee:** $855.80	**Benefit:** 75% = $641.85	85% = $782.10
23410	8:01 HOURS TO 8:10 HOURS (45 basic units) **Fee:** $875.25	**Benefit:** 75% = $656.45	85% = $801.55
23420	8:11 HOURS TO 8:20 HOURS (46 basic units) **Fee:** $894.70	**Benefit:** 75% = $671.05	85% = $821.00
23430	8:21 HOURS TO 8:30 HOURS (47 basic units) **Fee:** $914.15	**Benefit:** 75% = $685.65	85% = $840.45
23440	8:31 HOURS TO 8:40 HOURS (48 basic units) **Fee:** $933.60	**Benefit:** 75% = $700.20	85% = $859.90
23450	8:41 HOURS TO 8:50 HOURS (49 basic units) **Fee:** $953.05	**Benefit:** 75% = $714.80	85% = $879.35
23460	8:51 HOURS TO 9:00 HOURS (50 basic units) **Fee:** $972.50	**Benefit:** 75% = $729.40	85% = $898.80
23470	9:01 HOURS TO 9:10 HOURS (51 basic units) **Fee:** $991.95	**Benefit:** 75% = $744.00	85% = $918.25
23480	9:11 HOURS TO 9:20 HOURS (52 basic units) **Fee:** $1,011.40	**Benefit:** 75% = $758.55	85% = $937.70
23490	9:21 HOURS TO 9:30 HOURS (53 basic units) **Fee:** $1,030.85	**Benefit:** 75% = $773.15	85% = $957.15
23500	9:31 HOURS TO 9:40 HOURS (54 basic units) **Fee:** $1,050.30	**Benefit:** 75% = $787.75	85% = $976.60
23510	9:41 HOURS TO 9:50 HOURS (55 basic units) **Fee:** $1,069.75	**Benefit:** 75% = $802.35	85% = $996.05
23520	9:51 HOURS TO 10:00 HOURS (56 basic units) **Fee:** $1,089.20	**Benefit:** 75% = $816.90	85% = $1,015.50
23530	10:01 HOURS TO 10:10 HOURS (57 basic units) **Fee:** $1,108.65	**Benefit:** 75% = $831.50	85% = $1,034.95

23540	10:11 HOURS TO 10:20 HOURS (58 basic units) **Fee:** $1,128.10	**Benefit:** 75% = $846.10	85% = $1,054.40
23550	10:21 HOURS TO 10:30 HOURS (59 basic units) **Fee:** $1,147.55	**Benefit:** 75% = $860.70	85% = $1,073.85
23560	10:31 HOURS TO 10:40 HOURS (60 basic units) **Fee:** $1,167.00	**Benefit:** 75% = $875.25	85% = $1,093.30
23570	10:41 HOURS TO 10:50 HOURS (61 basic units) **Fee:** $1,186.45	**Benefit:** 75% = $889.85	85% = $1,112.75
23580	10:51 HOURS TO 11:00 HOURS (62 basic units) **Fee:** $1,205.90	**Benefit:** 75% = $904.45	85% = $1,132.20
23590	11:01 HOURS TO 11:10 HOURS (63 basic units) **Fee:** $1,225.35	**Benefit:** 75% = $919.05	85% = $1,151.65
23600	11:11 HOURS TO 11:20 HOURS (64 basic units) **Fee:** $1,244.80	**Benefit:** 75% = $933.60	85% = $1,171.10
23610	11:21 HOURS TO 11:30 HOURS (65 basic units) **Fee:** $1,264.25	**Benefit:** 75% = $948.20	85% = $1,190.55
23620	11:31 HOURS TO 11:40 HOURS (66 basic units) **Fee:** $1,283.70	**Benefit:** 75% = $962.80	85% = $1,210.00
23630	11:41 HOURS TO 11:50 HOURS (67 basic units) **Fee:** $1,303.15	**Benefit:** 75% = $977.40	85% = $1,229.45
23640	11:51 HOURS TO 12:00 HOURS (68 basic units) **Fee:** $1,322.60	**Benefit:** 75% = $991.95	85% = $1,248.90
23650	12:01 HOURS TO 12:10 HOURS (69 basic units) **Fee:** $1,342.05	**Benefit:** 75% = $1,006.55	85% = $1,268.35
23660	12:11 HOURS TO 12:20 HOURS (70 basic units) **Fee:** $1,361.50	**Benefit:** 75% = $1,021.15	85% = $1,287.80
23670	12:21 HOURS TO 12:30 HOURS (71 basic units) **Fee:** $1,380.95	**Benefit:** 75% = $1,035.75	85% = $1,307.25
23680	12:31 HOURS TO 12:40 HOURS (72 basic units) **Fee:** $1,400.40	**Benefit:** 75% = $1,050.30	85% = $1,326.70
23690	12:41 HOURS TO 12:50 HOURS (73 basic units) **Fee:** $1,419.85	**Benefit:** 75% = $1,064.90	85% = $1,346.15
23700	12:51 HOURS TO 13:00 HOURS (74 basic units) **Fee:** $1,439.30	**Benefit:** 75% = $1,079.50	85% = $1,365.60
23710	13:01 HOURS TO 13:10 HOURS (75 basic units) **Fee:** $1,458.75	**Benefit:** 75% = $1,094.10	85% = $1,385.05
23720	13:11 HOURS TO 13:20 HOURS (76 basic units) **Fee:** $1,478.20	**Benefit:** 75% = $1,108.65	85% = $1,404.50
23730	13:21 HOURS TO 13:30 HOURS (77 basic units) **Fee:** $1,497.65	**Benefit:** 75% = $1,123.25	85% = $1,423.95
23740	13:31 HOURS TO 13:40 HOURS (78 basic units) **Fee:** $1,517.10	**Benefit:** 75% = $1,137.85	85% = $1,443.40
23750	13:41 HOURS TO 13:50 HOURS (79 basic units) **Fee:** $1,536.55	**Benefit:** 75% = $1,152.45	85% = $1,462.85

23760	13:51 HOURS TO 14:00 HOURS (80 basic units) **Fee:** $1,556.00	**Benefit:** 75% = $1,167.00	85% = $1,482.30
23770	14:01 HOURS TO 14:10 HOURS (81 basic units) **Fee:** $1,575.45	**Benefit:** 75% = $1,181.60	85% = $1,501.75
23780	14:11 HOURS TO 14:20 HOURS (82 basic units) **Fee:** $1,594.90	**Benefit:** 75% = $1,196.20	85% = $1,521.20
23790	14:21 HOURS TO 14:30 HOURS (83 basic units) **Fee:** $1,614.35	**Benefit:** 75% = $1,210.80	85% = $1,540.65
23800	14:31 HOURS TO 14:40 HOURS (84 basic units) **Fee:** $1,633.80	**Benefit:** 75% = $1,225.35	85% = $1,560.10
23810	14:41 HOURS TO 14:50 HOURS (85 basic units) **Fee:** $1,653.25	**Benefit:** 75% = $1,239.95	85% = $1,579.55
23820	14:51 HOURS TO 15:00 HOURS (86 basic units) **Fee:** $1,672.70	**Benefit:** 75% = $1,254.55	85% = $1,599.00
23830	15:01 HOURS TO 15:10 HOURS (87 basic units) **Fee:** $1,692.15	**Benefit:** 75% = $1,269.15	85% = $1,618.45
23840	15:11 HOURS TO 15:20 HOURS (88 basic units) **Fee:** $1,711.60	**Benefit:** 75% = $1,283.70	85% = $1,637.90
23850	15:21 HOURS TO 15:30 HOURS (89 basic units) **Fee:** $1,731.05	**Benefit:** 75% = $1,298.30	85% = $1,657.35
23860	15:31 HOURS TO 15:40 HOURS (90 basic units) **Fee:** $1,750.50	**Benefit:** 75% = $1,312.90	85% = $1,676.80
23870	15:41 HOURS TO 15:50 HOURS (91 basic units) **Fee:** $1,769.95	**Benefit:** 75% = $1,327.50	85% = $1,696.25
23880	15:51 HOURS TO 16:00 HOURS (92 basic units) **Fee:** $1,789.40	**Benefit:** 75% = $1,342.05	85% = $1,715.70
23890	16:01 HOURS TO 16:10 HOURS (93 basic units) **Fee:** $1,808.85	**Benefit:** 75% = $1,356.65	85% = $1,735.15
23900	16:11 HOURS TO 16:20 HOURS (94 basic units) **Fee:** $1,828.30	**Benefit:** 75% = $1,371.25	85% = $1,754.60
23910	16:21 HOURS TO 16:30 HOURS (95 basic units) **Fee:** $1,847.75	**Benefit:** 75% = $1,385.85	85% = $1,774.05
23920	16:31 HOURS TO 16:40 HOURS (96 basic units) **Fee:** $1,867.20	**Benefit:** 75% = $1,400.40	85% = $1,793.50
23930	16:41 HOURS TO 16:50 HOURS (97 basic units) **Fee:** $1,886.65	**Benefit:** 75% = $1,415.00	85% = $1,812.95
23940	16:51 HOURS TO 17:00 HOURS (98 basic units) **Fee:** $1,906.10	**Benefit:** 75% = $1,429.60	85% = $1,832.40
23950	17:01 HOURS TO 17:10 HOURS (99 basic units) **Fee:** $1,925.55	**Benefit:** 75% = $1,444.20	85% = $1,851.85
23960	17:11 HOURS TO 17:20 HOURS (100 basic units) **Fee:** $1,945.00	**Benefit:** 75% = $1,458.75	85% = $1,871.30
23970	17:21 HOURS TO 17:30 HOURS (101 basic units) **Fee:** $1,964.45	**Benefit:** 75% = $1,473.35	85% = $1,890.75

23980	17:31 HOURS TO 17:40 HOURS (102 basic units) **Fee:** $1,983.90	**Benefit:** 75% = $1,487.95	85% = $1,910.20
23990	17:41 HOURS TO 17:50 HOURS (103 basic units) **Fee:** $2,003.35	**Benefit:** 75% = $1,502.55	85% = $1,929.65
24100	17:51 HOURS TO 18:00 HOURS (104 basic units) **Fee:** $2,022.80	**Benefit:** 75% = $1,517.10	85% = $1,949.10
24101	18:01 HOURS TO 18:10 HOURS (105 basic units) **Fee:** $2,042.25	**Benefit:** 75% = $1,531.70	85% = $1,968.55
24102	18:11 HOURS TO 18:20 HOURS (106 basic units) **Fee:** $2,061.70	**Benefit:** 75% = $1,546.30	85% = $1,988.00
24103	18:21 HOURS TO 18:30 HOURS (107 basic units) **Fee:** $2,081.15	**Benefit:** 75% = $1,560.90	85% = $2,007.45
24104	18:31 HOURS TO 18:40 HOURS (108 basic units) **Fee:** $2,100.60	**Benefit:** 75% = $1,575.45	85% = $2,026.90
24105	18:41 HOURS TO 18:50 HOURS (109 basic units) **Fee:** $2,120.05	**Benefit:** 75% = $1,590.05	85% = $2,046.35
24106	18:51 HOURS TO 19:00 HOURS (110 basic units) **Fee:** $2,139.50	**Benefit:** 75% = $1,604.65	85% = $2,065.80
24107	19:01 HOURS TO 19:10 HOURS (111 basic units) **Fee:** $2,158.95	**Benefit:** 75% = $1,619.25	85% = $2,085.25
24108	19:11 HOURS TO 19:20 HOURS (112 basic units) **Fee:** $2,178.40	**Benefit:** 75% = $1,633.80	85% = $2,104.70
24109	19:21 HOURS TO 19:30 HOURS (113 basic units) **Fee:** $2,197.85	**Benefit:** 75% = $1,648.40	85% = $2,124.15
24110	19:31 HOURS TO 19:40 HOURS (114 basic units) **Fee:** $2,217.30	**Benefit:** 75% = $1,663.00	85% = $2,143.60
24111	19:41 HOURS TO 19:50 HOURS (115 basic units) **Fee:** $2,236.75	**Benefit:** 75% = $1,677.60	85% = $2,163.05
24112	19:51 HOURS TO 20:00 HOURS (116 basic units) **Fee:** $2,256.20	**Benefit:** 75% = $1,692.15	85% = $2,182.50
24113	20:01 HOURS TO 20:10 HOURS (117 basic units) **Fee:** $2,275.65	**Benefit:** 75% = $1,706.75	85% = $2,201.95
24114	20:11 HOURS TO 20:20 HOURS (118 basic units) **Fee:** $2,295.10	**Benefit:** 75% = $1,721.35	85% = $2,221.40
24115	20:21 HOURS TO 20:30 HOURS (119 basic units) **Fee:** $2,314.55	**Benefit:** 75% = $1,735.95	85% = $2,240.85
24116	20:31 HOURS TO 20:40 HOURS (120 basic units) **Fee:** $2,334.00	**Benefit:** 75% = $1,750.50	85% = $2,260.30
24117	20:41 HOURS TO 20:50 HOURS (121 basic units) **Fee:** $2,353.45	**Benefit:** 75% = $1,765.10	85% = $2,279.75
24118	20:51 HOURS TO 21:00 HOURS (122 basic units) **Fee:** $2,372.90	**Benefit:** 75% = $1,779.70	85% = $2,299.20
24119	21:01 HOURS TO 21:10 HOURS (123 basic units) **Fee:** $2,392.35	**Benefit:** 75% = $1,794.30	85% = $2,318.65

24120	21:11 HOURS TO 21:20 HOURS (124 basic units) **Fee:** $2,411.80	**Benefit:** 75% = $1,808.85	85% = $2,338.10
24121	21:21 HOURS TO 21:30 HOURS (125 basic units) **Fee:** $2,431.25	**Benefit:** 75% = $1,823.45	85% = $2,357.55
24122	21:31 HOURS TO 21:40 HOURS (126 basic units) **Fee:** $2,450.70	**Benefit:** 75% = $1,838.05	85% = $2,377.00
24123	21:41 HOURS TO 21:50 HOURS (127 basic units) **Fee:** $2,470.15	**Benefit:** 75% = $1,852.65	85% = $2,396.45
24124	21:51 HOURS TO 22:00 HOURS (128 basic units) **Fee:** $2,489.60	**Benefit:** 75% = $1,867.20	85% = $2,415.90
24125	22:01 HOURS TO 22:10 HOURS (129 basic units) **Fee:** $2,509.05	**Benefit:** 75% = $1,881.80	85% = $2,435.35
24126	22:11 HOURS TO 22:20 HOURS (130 basic units) **Fee:** $2,528.50	**Benefit:** 75% = $1,896.40	85% = $2,454.80
24127	22:21 HOURS TO 22:30 HOURS (131 basic units) **Fee:** $2,547.95	**Benefit:** 75% = $1,911.00	85% = $2,474.25
24128	22:31 HOURS TO 22:40 HOURS (132 basic units) **Fee:** $2,567.40	**Benefit:** 75% = $1,925.55	85% = $2,493.70
24129	22:41 HOURS TO 22:50 HOURS (133 basic units) **Fee:** $2,586.85	**Benefit:** 75% = $1,940.15	85% = $2,513.15
24130	22:51 HOURS TO 23:00 HOURS (134 basic units) **Fee:** $2,606.30	**Benefit:** 75% = $1,954.75	85% = $2,532.60
24131	23:01 HOURS TO 23:10 HOURS (135 basic units) **Fee:** $2,625.75	**Benefit:** 75% = $1,969.35	85% = $2,552.05
24132	23:11 HOURS TO 23:20 HOURS (136 basic units) **Fee:** $2,645.20	**Benefit:** 75% = $1,983.90	85% = $2,571.50
24133	23:21 HOURS TO 23:30 HOURS (137 basic units) **Fee:** $2,664.65	**Benefit:** 75% = $1,998.50	85% = $2,590.95
24134	23:31 HOURS TO 23:40 HOURS (138 basic units) **Fee:** $2,684.10	**Benefit:** 75% = $2,013.10	85% = $2,610.40
24135	23:41 HOURS TO 23:50 HOURS (139 basic units) **Fee:** $2,703.55	**Benefit:** 75% = $2,027.70	85% = $2,629.85
24136	23:51 HOURS TO 24:00 HOURS (140 basic units) **Fee:** $2,723.00	**Benefit:** 75% = $2,042.25	85% = $2,649.30
	SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS		
25000	**ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA** (a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) for perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205 Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $19.45	**Benefit:** 75% = $14.60	85% = $16.55
25005	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $38.90	**Benefit:** 75% = $29.20	85% = $33.10

25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $58.35 **Benefit:** 75% = $43.80 85% = $49.60
	SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER
25015	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** - where the patient is less than 12 months of age or 70 years or greater (1 basic units) **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
25020	**ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA** - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 basic units) *(See para T10.3 of explanatory notes to this Category)* **Fee:** $38.90 **Benefit:** 75% = $29.20 85% = $33.10
	SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER
25025	**EMERGENCY ANAESTHESIA** performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051
25030	**ASSISTANCE AT AFTER HOURS EMERGENCY ANAESTHESIA** where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25050 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051
	SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER
25050	**AFTER HOURS EMERGENCY PERFUSION** where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies *(See para T10.3 of explanatory notes to this Category)* **Derived Fee:** An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 25015, plus (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001-22051 or 22065-22075
	SUBGROUP 26 - ASSISTANCE AT ANAESTHESIA
25200	**ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA** on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units) *(See para T10.9 of explanatory notes to this Category)* **Derived Fee:** An amount of $97.25 (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

25205	**ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA** where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; or (v) where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (5 basic units) *(See para T10.9 of explanatory notes to this Category)* **Derived Fee:** An amount of $97.25 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds *(See para T8.5 of explanatory notes to this Category)* **Derived Fee:** 50% of the fee which would have applied had the procedure not been discontinued
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $35.60 **Benefit:** 75% = $26.70 85% = $30.30
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation **Fee:** $45.65 **Benefit:** 75% = $34.25 85% = $38.85
30009 G 30010 S	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) **Fee:** $59.60 **Benefit:** 75% = $44.70 **Fee:** $72.50 **Benefit:** 75% = $54.40
30013 G 30014 S	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) **Fee:** $128.45 **Benefit:** 75% = $96.35 **Fee:** $152.50 **Benefit:** 75% = $114.40
30017	BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
30020	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) **Fee:** $623.15 **Benefit:** 75% = $467.40
30023	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
30024	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $51.25 **Benefit:** 75% = $38.45 85% = $43.60
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $88.30 **Benefit:** 75% = $66.25 85% = $75.10
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $80.95 **Benefit:** 75% = $60.75 85% = $68.85
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05

30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $88.30	**Benefit:** 75% = $66.25	85% = $75.10
30041 G 30042 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $141.30 **Fee:** $182.15	**Benefit:** 75% = $106.00 **Benefit:** 75% = $136.65	85% = $120.15 85% = $154.85
30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $115.35	**Benefit:** 75% = $86.55	85% = $98.05
30048 G 30049 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) *(See para T8.6 of explanatory notes to this Category)* **Fee:** $146.95 **Fee:** $182.15	**Benefit:** 75% = $110.25 **Benefit:** 75% = $136.65	85% = $124.95 85% = $154.85
30052	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) **Fee:** $249.25	**Benefit:** 75% = $186.95	85% = $211.90
30055	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $72.50	**Benefit:** 75% = $54.40	85% = $61.65
30058	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.) **Fee:** $141.65	**Benefit:** 75% = $106.25	85% = $120.45
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.) **Fee:** $23.05	**Benefit:** 75% = $17.30	85% = $19.60
30062	Etonogestrel subcutaneous implant, removal of, as an independent procedure (Anaes.) **Fee:** $59.60	**Benefit:** 75% = $44.70	85% = $50.70
30064	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.) **Fee:** $107.85	**Benefit:** 75% = $80.90	85% = $91.70
30067 G 30068 S	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.) **Fee:** $219.45 **Fee:** $271.65	**Benefit:** 75% = $164.60 **Benefit:** 75% = $203.75	85% = $186.55 85% = $230.95
30071	DIAGNOSTIC BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $51.25	**Benefit:** 75% = $38.45	85% = $43.60
30074 G 30075 S	DIAGNOSTIC BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $115.35 **Fee:** $146.95	**Benefit:** 75% = $86.55 **Benefit:** 75% = $110.25	85% = $98.05 85% = $124.95
30078	DIAGNOSTIC DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $47.55	**Benefit:** 75% = $35.70	85% = $40.45

30081	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $107.85	**Benefit:** 75% = $80.90	85% = $91.70
30084	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach with a Jamshidi needle or similar device, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $57.70	**Benefit:** 75% = $43.30	85% = $49.05
30087	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $28.90	**Benefit:** 75% = $21.70	85% = $24.60
30090	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $126.15	**Benefit:** 75% = $94.65	85% = $107.25
30093	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $168.35	**Benefit:** 75% = $126.30	85% = $143.10
30094	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $185.85	**Benefit:** 75% = $139.40	85% = $158.00
30096	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.) *(See para T8.7 of explanatory notes to this Category)* **Fee:** $180.45	**Benefit:** 75% = $135.35	85% = $153.40
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented. **Fee:** $95.35	**Benefit:** 75% = $71.55	85% = $81.05
30099	SINUS, excision of, involving superficial tissue only (Anaes.) **Fee:** $88.30	**Benefit:** 75% = $66.25	85% = $75.10
30102 G 30103 S	SINUS, excision of, involving muscle and deep tissue (Anaes.) **Fee:** $146.95 **Fee:** $180.45	**Benefit:** 75% = $110.25 **Benefit:** 75% = $135.35	85% = $124.95 85% = $153.40
30104	PRE-AURICULAR SINUS, excision of (Anaes.) **Fee:** $124.55	**Benefit:** 75% = $93.45	85% = $105.90
30106 G 30107 S	GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $152.50 **Fee:** $215.85	**Benefit:** 75% = $114.40 **Benefit:** 75% = $161.90	85% = $129.65 85% = $183.50
30110 G 30111 S	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.) **Fee:** $279.05 **Fee:** $364.55	**Benefit:** 75% = $209.30 **Benefit:** 75% = $273.45	85% = $237.20 85% = $309.90
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.) **Fee:** $364.55	**Benefit:** 75% = $273.45	
30165	LIPECTOMY transverse wedge excision of abdominal apron, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $446.35	**Benefit:** 75% = $334.80	85% = $379.40

30168	LIPECTOMY wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 1 EXCISION (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $446.35 **Benefit:** 75% = $334.80 85% = $379.40
30171	LIPECTOMY wedge excision of skin and fat, not being a service associated with items 45564, 45565 or 45530 and not being a service to which item 30165 applies, 2 OR MORE EXCISIONS (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $678.85 **Benefit:** 75% = $509.15 85% = $605.15
30174	LIPECTOMY subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall, not being a service associated with items 45564 or 45565 or 45530 (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $678.85 **Benefit:** 75% = $509.15 85% = $605.15
30177	LIPECTOMY radical abdominoplasty (Pitanguy type or similar), with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a service performed within 12 months after the end of a pregnancy and not being a service associated with a service to which item 45564, 45565 or 45530 applies (Anaes.) (Assist.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $967.30 **Benefit:** 75% = $725.50
30180	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.) **Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) **Fee:** $241.90 **Benefit:** 75% = $181.45 85% = $205.65
30185	PALMAR OR PLANTAR WARTS (10 or more), definitive removal of, excluding ablative methods alone, not being a service to which item 30186 or 30187 applies (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $179.10 **Benefit:** 75% = $134.35 85% = $152.25
30186	PALMAR OR PLANTAR WARTS (less than 10), definitive removal of, excluding ablative methods alone, not being a service to which item 30185 or 30187 applies (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $46.55 **Benefit:** 75% = $34.95 85% = $39.60
30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $252.15 **Benefit:** 75% = $189.15 85% = $214.35
30189	WARTS or MOLLUSCUM CONTAGIOSUM (one or more), removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $144.55 **Benefit:** 75% = $108.45 85% = $122.90
30190	ANGIOFIBROMAS, TRICHOEPITHELIOMAS or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser or erbium laser excision-ablation including associated resurfacing (10 or more tumours) (Anaes.) (Assist.) **Fee:** $390.35 **Benefit:** 75% = $292.80 85% = $331.80
30192	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $38.80 **Benefit:** 75% = $29.10 85% = $33.00
30195	BENIGN NEOPLASM OF SKIN, other than viral verrucae (common warts) seborrheic keratoses, cysts and skin tags, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which item 30196, 30197, 30202, 30203 or 30205 applies (1 or more lesions) (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $62.30 **Benefit:** 75% = $46.75 85% = $53.00

30196	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $123.95 **Benefit:** 75% = $93.00 85% = $105.40
30197	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 OR MORE LESIONS) (Anaes.) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $431.85 **Benefit:** 75% = $323.90 85% = $367.10
30202	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies *(See para T8.10 of explanatory notes to this Category)* **Fee:** $47.45 **Benefit:** 75% = $35.60 85% = $40.35
30203	MALIGNANT NEOPLASM OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $167.10 **Benefit:** 75% = $125.35 85% = $142.05
30205	MALIGNANT NEOPLASM OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE THE MALIGNANT NEOPLASM EXTENDS INTO CARTILAGE (Anaes.) **Fee:** $123.95 **Benefit:** 75% = $93.00 85% = $105.40
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes.) **Fee:** $43.75 **Benefit:** 75% = $32.85 85% = $37.20
30210	KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $159.90 **Benefit:** 75% = $119.95 85% = $135.95
30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.) *(See para T8.11 of explanatory notes to this Category)* **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60
30214	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - <u>session of at least 20 minutes duration</u> - ***where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period*** *(See para T8.11 of explanatory notes to this Category)* **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60
30216	HAEMATOMA, aspiration of (Anaes.) **Fee:** $26.85 **Benefit:** 75% = $20.15 85% = $22.85
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital - INCISION WITH DRAINAGE OF (excluding aftercare) **Fee:** $26.85 **Benefit:** 75% = $20.15 85% = $22.85
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) **Fee:** $159.90 **Benefit:** 75% = $119.95
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $233.15 **Benefit:** 75% = $174.90 85% = $198.20
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $262.65 **Benefit:** 75% = $197.00 85% = $223.30
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95

30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) **Fee:** $219.45 **Benefit:** 75% = $164.60 85% = $186.55
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65 85% = $246.70
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30 85% = $297.25
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) **Fee:** $676.95 **Benefit:** 75% = $507.75
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) **Fee:** $725.55 **Benefit:** 75% = $544.20
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,227.75 **Benefit:** 75% = $920.85
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) **Fee:** $1,885.90 **Benefit:** 75% = $1,414.45 85% = $1,812.20
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) **Fee:** $818.50 **Benefit:** 75% = $613.90
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) **Fee:** $1,089.95 **Benefit:** 75% = $817.50
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) **Fee:** $437.10 **Benefit:** 75% = $327.85
30259	SUBLINGUAL GLAND, extirpation of (Anaes.) **Fee:** $194.80 **Benefit:** 75% = $146.10 85% = $165.60
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) **Fee:** $57.70 **Benefit:** 75% = $43.30 85% = $49.05
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05 **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95
30272	TONGUE, partial excision of (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65 85% = $246.70
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.) **Fee:** $1,729.90 **Benefit:** 75% = $1,297.45
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) **Fee:** $45.65 **Benefit:** 75% = $34.25 85% = $38.85
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70

30282 G 30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) **Fee:** $152.50 **Benefit:** 75% = $114.40 85% = $129.65 **Fee:** $200.90 **Benefit:** 75% = $150.70 85% = $170.80
30286	BRANCHIAL CYST, removal of (Anaes.) (Assist.) **Fee:** $390.45 **Benefit:** 75% = $292.85 85% = $331.90
30289	BRANCHIAL FISTULA, removal of (Anaes.) (Assist.) **Fee:** $492.90 **Benefit:** 75% = $369.70
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) **Fee:** $437.10 **Benefit:** 75% = $327.85 85% = $371.55
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) **Fee:** $1,729.90 **Benefit:** 75% = $1,297.45
30296	THYROIDECTOMY, total (Anaes.) (Assist.) **Fee:** $1,004.60 **Benefit:** 75% = $753.45
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) **Fee:** $1,004.60 **Benefit:** 75% = $753.45
30299	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $625.55 **Benefit:** 75% = $469.20
30300	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $750.65 **Benefit:** 75% = $563.00
30302	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level I axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $500.45 **Benefit:** 75% = $375.35
30303	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $600.45 **Benefit:** 75% = $450.35
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) **Fee:** $783.75 **Benefit:** 75% = $587.85
30308	BILATERAL SUBTOTAL THYROIDECTOMY (Anaes.) (Assist.) **Fee:** $783.75 **Benefit:** 75% = $587.85
30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assist.) **Fee:** $1,004.60 **Benefit:** 75% = $753.45
30310	THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.) (Assist.) **Fee:** $448.85 **Benefit:** 75% = $336.65
30313	THYROGLOSSAL CYST, removal of (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
30314	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) **Fee:** $448.85 **Benefit:** 75% = $336.65

30315	PARATHYROID operation for hyperparathyroidism (Anaes.) (Assist.) **Fee:** $1,118.65 **Benefit:** 75% = $839.00
30317	CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes.) (Assist.) **Fee:** $1,339.45 **Benefit:** 75% = $1,004.60
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) **Fee:** $890.70 **Benefit:** 75% = $668.05
30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) **Fee:** $1,339.45 **Benefit:** 75% = $1,004.60
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes.) (Assist.) **Fee:** $890.70 **Benefit:** 75% = $668.05
30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes.) (Assist.) **Fee:** $1,339.45 **Benefit:** 75% = $1,004.60
30324	ADRENAL GLAND TUMOUR, excision of (Anaes.) (Assist.) **Fee:** $1,339.45 **Benefit:** 75% = $1,004.60
30329	LYMPH GLANDS of GROIN, limited excision of (Anaes.) **Fee:** $242.35 **Benefit:** 75% = $181.80 85% = $206.00
30330	LYMPH GLANDS of GROIN, radical excision of (Anaes.) (Assist.) **Fee:** $705.35 **Benefit:** 75% = $529.05
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) **Fee:** $340.30 **Benefit:** 75% = $255.25
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $850.70 **Benefit:** 75% = $638.05
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $1,020.85 **Benefit:** 75% = $765.65
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $474.25 **Benefit:** 75% = $355.70
30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $511.55 **Benefit:** 75% = $383.70
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
30378	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours (Anaes.) (Assist.) **Fee:** $513.95 **Benefit:** 75% = $385.50
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) **Fee:** $910.85 **Benefit:** 75% = $683.15
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) **Fee:** $1,282.55 **Benefit:** 75% = $961.95
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.) **Fee:** $1,078.90 **Benefit:** 75% = $809.20

30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $623.15 **Benefit:** 75% = $467.40
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) **Fee:** $1,567.75 **Benefit:** 75% = $1,175.85
30390	LAPAROSCOPY, diagnostic, not being a service associated with any other laparoscopic procedure (Anaes.) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $215.85 **Benefit:** 75% = $161.90
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) **Fee:** $279.05 **Benefit:** 75% = $209.30
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) **Fee:** $661.90 **Benefit:** 75% = $496.45
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) **Fee:** $513.95 **Benefit:** 75% = $385.50
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.) **Fee:** $483.65 **Benefit:** 75% = $362.75
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.) (Assist.) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $997.60 **Benefit:** 75% = $748.20
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.) **Fee:** $228.00 **Benefit:** 75% = $171.00
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes.) (Assist.) **Fee:** $313.65 **Benefit:** 75% = $235.25
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) **Fee:** $620.70 **Benefit:** 75% = $465.55
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) **Fee:** $455.95 **Benefit:** 75% = $342.00
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or without mesh (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
30405	VENTRAL OR INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.) **Fee:** $897.90 **Benefit:** 75% = $673.45
30406	PARACENTESIS ABDOMINIS (Anaes.) **Fee:** $51.25 **Benefit:** 75% = $38.45 85% = $43.60
30408	PERITONEOVENOUS shunt, insertion of (Anaes.) (Assist.) **Fee:** $384.80 **Benefit:** 75% = $288.60
30409	LIVER BIOPSY, percutaneous (Anaes.) **Fee:** $171.20 **Benefit:** 75% = $128.40 85% = $145.55

OPERATIONS	GENERAL
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) **Fee:** $87.15 **Benefit:** 75% = $65.40
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) **Fee:** $51.35 **Benefit:** 75% = $38.55 85% = $43.65
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) **Fee:** $676.95 **Benefit:** 75% = $507.75
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,353.80 **Benefit:** 75% = $1,015.35
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $735.00 **Benefit:** 75% = $551.25
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) **Fee:** $1,102.45 **Benefit:** 75% = $826.85
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,567.75 **Benefit:** 75% = $1,175.85
30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.) **Fee:** $801.85 **Benefit:** 75% = $601.40 85% = $728.15
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.) **Fee:** $1,959.30 **Benefit:** 75% = $1,469.50
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) **Fee:** $662.75 **Benefit:** 75% = $497.10
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) **Fee:** $1,282.55 **Benefit:** 75% = $961.95
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) **Fee:** $1,531.85 **Benefit:** 75% = $1,148.90
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) **Fee:** $1,638.85 **Benefit:** 75% = $1,229.15 85% = $1,565.15
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.) **Fee:** $2,280.00 **Benefit:** 75% = $1,710.00 85% = $2,206.30
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70 85% = $437.85
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.) **Fee:** $577.20 **Benefit:** 75% = $432.90
30436	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.) **Fee:** $641.25 **Benefit:** 75% = $480.95
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.) **Fee:** $798.15 **Benefit:** 75% = $598.65
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.) **Fee:** $1,129.40 **Benefit:** 75% = $847.05 85% = $1,055.70
30439	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.) **Fee:** $182.15 **Benefit:** 75% = $136.65

30440	CHOLANGIOGRAM, percutaneous transhepatic, and insertion of biliary drainage tube, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30451 applies (Anaes.) (Assist.) **Fee:** $516.60 **Benefit:** 75% = $387.45 85% = $442.90
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.) **Fee:** $133.70 **Benefit:** 75% = $100.30
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) **Fee:** $182.15 **Benefit:** 75% = $136.65
30443	CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $725.55 **Benefit:** 75% = $544.20
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.) **Fee:** $725.55 **Benefit:** 75% = $544.20
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.) **Fee:** $725.55 **Benefit:** 75% = $544.20
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.) **Fee:** $954.75 **Benefit:** 75% = $716.10
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.) **Fee:** $1,061.70 **Benefit:** 75% = $796.30
30450	CALCULUS OF BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627, 36630, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $514.60 **Benefit:** 75% = $385.95 85% = $440.90
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging, not being a service associated with a service to which item 30440 applies (Anaes.) (Assist.) **Fee:** $262.65 **Benefit:** 75% = $197.00 85% = $223.30
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) **Fee:** $370.45 **Benefit:** 75% = $277.85
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.) **Fee:** $846.40 **Benefit:** 75% = $634.80
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.) **Fee:** $995.15 **Benefit:** 75% = $746.40
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) **Fee:** $1,353.80 **Benefit:** 75% = $1,015.35 85% = $1,280.10
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.) **Fee:** $995.15 **Benefit:** 75% = $746.40
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) **Fee:** $846.40 **Benefit:** 75% = $634.80
30461	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.) **Fee:** $1,450.85 **Benefit:** 75% = $1,088.15
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $1,781.35 **Benefit:** 75% = $1,336.05
30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.) **Fee:** $2,137.65 **Benefit:** 75% = $1,603.25

30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,232.65 **Benefit:** 75% = $924.50
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) **Fee:** $1,524.75 **Benefit:** 75% = $1,143.60
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) **Fee:** $1,688.80 **Benefit:** 75% = $1,266.60 85% = $1,615.10
30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.) **Fee:** $912.00 **Benefit:** 75% = $684.00 85% = $838.30
30473	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $173.80 **Benefit:** 75% = $130.35 85% = $147.75
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $314.30 **Benefit:** 75% = $235.75 85% = $267.20
30476	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $240.95 **Benefit:** 75% = $180.75 85% = $204.85
30478	OESOPHAGOSCOPY (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $240.95 **Benefit:** 75% = $180.75 85% = $204.85
30479	ENDOSCOPY with LASER THERAPY or ARGON PLASMA COAGULATION, for the treatment of neoplasia, benign vascular lesions, strictures of the gastrointestinal tract, tumorous overgrowth through or over oesophageal stents, peptic ulcers, angiodysplasia, gastric antral vascular ectasia (GAVE) or post-polypectomy bleeding, 1 or more of (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $467.20 **Benefit:** 75% = $350.40 85% = $397.15
30481	PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $350.35 **Benefit:** 75% = $262.80 85% = $297.80
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes.) **Fee:** $249.10 **Benefit:** 75% = $186.85 85% = $211.75
30483	GASTROSTOMY BUTTON, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.) **Fee:** $173.75 **Benefit:** 75% = $130.35 85% = $147.70
30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $358.10 **Benefit:** 75% = $268.60 85% = $304.40
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $552.80 **Benefit:** 75% = $414.60 85% = $479.10
30487	SMALL BOWEL INTUBATION with biopsy, as an independent procedure (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $177.55 **Benefit:** 75% = $133.20 85% = $150.95
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) **Fee:** $88.30 **Benefit:** 75% = $66.25 85% = $75.10

30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $516.60 **Benefit:** 75% = $387.45 85% = $442.90
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $545.00 **Benefit:** 75% = $408.75 85% = $471.30
30492	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performed), using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $772.60 **Benefit:** 75% = $579.45
30493	BILIARY MANOMETRY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $327.00 **Benefit:** 75% = $245.25 85% = $277.95
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $412.65 **Benefit:** 75% = $309.50
30495	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional imaging techniques - but not including imaging (Anaes.) **Fee:** $772.60 **Benefit:** 75% = $579.45
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $577.20 **Benefit:** 75% = $432.90 85% = $503.50
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) **Fee:** $688.20 **Benefit:** 75% = $516.15
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) **Fee:** $818.50 **Benefit:** 75% = $613.90
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) **Fee:** $876.45 **Benefit:** 75% = $657.35 85% = $802.75
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) **Fee:** $967.30 **Benefit:** 75% = $725.50
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) **Fee:** $1,083.20 **Benefit:** 75% = $812.40 85% = $1,009.50
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) **Fee:** $541.55 **Benefit:** 75% = $406.20
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) **Fee:** $947.75 **Benefit:** 75% = $710.85
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) **Fee:** $997.60 **Benefit:** 75% = $748.20
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) **Fee:** $997.60 **Benefit:** 75% = $748.20 85% = $923.90
30511	(*see Item 31441 for repair, revision or replacement of implanted reservoir associated with adjustable gastric band*) (*see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band*) MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes.) (Assist.) **Fee:** $833.70 **Benefit:** 75% = $625.30
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.) **Fee:** $1,025.90 **Benefit:** 75% = $769.45

30514	MORBID OBESITY, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.) *(See para T8.18 of explanatory notes to this Category)* **Fee:** $1,510.40 **Benefit:** 75% = $1,132.80
30515	GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (Anaes.) (Assist.) **Fee:** $691.20 **Benefit:** 75% = $518.40
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) **Fee:** $905.00 **Benefit:** 75% = $678.75
30518	PARTIAL GASTRECTOMY (Anaes.) (Assist.) **Fee:** $969.10 **Benefit:** 75% = $726.85
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) **Fee:** $662.75 **Benefit:** 75% = $497.10
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) **Fee:** $1,417.95 **Benefit:** 75% = $1,063.50
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $1,481.95 **Benefit:** 75% = $1,111.50
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) **Fee:** $1,631.65 **Benefit:** 75% = $1,223.75
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.) **Fee:** $2,116.15 **Benefit:** 75% = $1,587.15
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $855.05 **Benefit:** 75% = $641.30
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $1,282.55 **Benefit:** 75% = $961.95
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $769.60 **Benefit:** 75% = $577.20
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $883.65 **Benefit:** 75% = $662.75
30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $1,051.05 **Benefit:** 75% = $788.30
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) **Fee:** $1,665.00 **Benefit:** 75% = $1,248.75
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,688.80 **Benefit:** 75% = $1,266.60
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,168.60 **Benefit:** 75% = $876.45

30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) **Fee:** $855.05 **Benefit:** 75% = $641.30
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,489.20 **Benefit:** 75% = $1,116.90
30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,011.85 **Benefit:** 75% = $758.90
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) **Fee:** $741.10 **Benefit:** 75% = $555.85
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,802.85 **Benefit:** 75% = $1,352.15
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,239.80 **Benefit:** 75% = $929.85 85% = $1,166.10
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) **Fee:** $926.20 **Benefit:** 75% = $694.65 85% = $852.50
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.) **Fee:** $2,023.75 **Benefit:** 75% = $1,517.85
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,396.60 **Benefit:** 75% = $1,047.45
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,033.00 **Benefit:** 75% = $774.75 85% = $959.30
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) **Fee:** $2,251.65 **Benefit:** 75% = $1,688.75
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,553.30 **Benefit:** 75% = $1,165.00
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,147.20 **Benefit:** 75% = $860.40
30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) **Fee:** $833.70 **Benefit:** 75% = $625.30 85% = $760.00
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.) **Fee:** $926.20 **Benefit:** 75% = $694.65
30562	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel (Anaes.) (Assist.) **Fee:** $583.90 **Benefit:** 75% = $437.95
30563	COLOSTOMY OR ILEOSTOMY, refashioning of (Anaes.) (Assist.) **Fee:** $583.90 **Benefit:** 75% = $437.95 85% = $510.20
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.) **Fee:** $757.90 **Benefit:** 75% = $568.45
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) **Fee:** $855.05 **Benefit:** 75% = $641.30

30566	SMALL INTESTINE, resection of, with anastomosis (Anaes.) (Assist.) **Fee:** $949.80 **Benefit:** 75% = $712.35
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.) **Fee:** $363.30 **Benefit:** 75% = $272.50
30571	APPENDICECTOMY, not being a service to which item 30574 applies (Anaes.) (Assist.) **Fee:** $437.10 **Benefit:** 75% = $327.85
30572	LAPAROSCOPIC APPENDICECTOMY (Anaes.) (Assist.) **Fee:** $437.10 **Benefit:** 75% = $327.85
30574	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item* APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.) **Fee:** $120.95 **Benefit:** 75% = $90.75
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.) **Fee:** $503.15 **Benefit:** 75% = $377.40
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.) **Fee:** $1,068.85 **Benefit:** 75% = $801.65
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.) **Fee:** $1,125.80 **Benefit:** 75% = $844.35
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.) **Fee:** $1,025.90 **Benefit:** 75% = $769.45
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.) **Fee:** $748.15 **Benefit:** 75% = $561.15
30583	DISTAL PANCREATECTOMY (Anaes.) (Assist.) **Fee:** $1,172.00 **Benefit:** 75% = $879.00
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.) **Fee:** $1,729.90 **Benefit:** 75% = $1,297.45
30586	PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.) **Fee:** $688.20 **Benefit:** 75% = $516.15
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.) **Fee:** $712.50 **Benefit:** 75% = $534.40
30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.) **Fee:** $1,227.75 **Benefit:** 75% = $920.85
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.) **Fee:** $1,353.80 **Benefit:** 75% = $1,015.35
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.) **Fee:** $1,852.55 **Benefit:** 75% = $1,389.45 85% = $1,778.85
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.) **Fee:** $2,137.65 **Benefit:** 75% = $1,603.25
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.) **Fee:** $880.55 **Benefit:** 75% = $660.45
30597	SPLENECTOMY (Anaes.) (Assist.) **Fee:** $706.75 **Benefit:** 75% = $530.10

30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.) **Fee:** $1,282.55 **Benefit:** 75% = $961.95
30600	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.) **Fee:** $762.60 **Benefit:** 75% = $571.95
30601	DIAPHRAGMATIC HERNIA, CONGENITAL repair of, by thoracic or abdominal approach (Anaes.) (Assist.) **Fee:** $939.45 **Benefit:** 75% = $704.60
30602	PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.) **Fee:** $1,524.75 **Benefit:** 75% = $1,143.60
30603	PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.) **Fee:** $1,610.30 **Benefit:** 75% = $1,207.75 85% = $1,536.60
30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.) **Fee:** $1,831.15 **Benefit:** 75% = $1,373.40
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) **Fee:** $1,090.10 **Benefit:** 75% = $817.60
30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Anaes.) (Assist.) **Fee:** $455.85 **Benefit:** 75% = $341.90
30612 G 30614 S	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30 **Fee:** $455.85 **Benefit:** 75% = $341.90
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
30616 G 30617 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (Anaes.) **Fee:** $260.35 **Benefit:** 75% = $195.30 **Fee:** $349.70 **Benefit:** 75% = $262.30
30620 G 30621 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (Anaes.) (Assist.) **Fee:** $293.85 **Benefit:** 75% = $220.40 **Fee:** $399.90 **Benefit:** 75% = $299.95
30628	HYDROCELE, tapping of **Fee:** $34.95 **Benefit:** 75% = $26.25 85% = $29.75
30631	HYDROCELE, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (Anaes.) **Fee:** $232.25 **Benefit:** 75% = $174.20 85% = $197.45
30634 G 30635 S	VARICOCELE, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (Anaes.) (Assist.) **Fee:** $230.65 **Benefit:** 75% = $173.00 **Fee:** $286.35 **Benefit:** 75% = $214.80
30638 G 30641 S	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.) **Fee:** $293.85 **Benefit:** 75% = $220.40 **Fee:** $399.90 **Benefit:** 75% = $299.95
30644	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
30653	CIRCUMCISION of a male UNDER 6 MONTHS of age (Anaes.) **Fee:** $45.65 **Benefit:** 75% = $34.25 85% = $38.85
30656	CIRCUMCISION of a male UNDER 10 YEARS of age but not less than 6 months of age (Anaes.) **Fee:** $106.15 **Benefit:** 75% = $79.65 85% = $90.25

30659 G 30660 S	CIRCUMCISION of a male 10 YEARS OF AGE OR OVER (Anaes.) **Fee:** $146.95 **Benefit:** 75% = $110.25 85% = $124.95 **Fee:** $182.15 **Benefit:** 75% = $136.65 85% = $154.85
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (Anaes.) **Fee:** $141.65 **Benefit:** 75% = $106.25 85% = $120.45
30666	PARAPHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $46.55 **Benefit:** 75% = $34.95 85% = $39.60
30672	COCCYX, excision of (Anaes.) (Assist.) **Fee:** $437.10 **Benefit:** 75% = $327.85
30675 G 30676 S	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.) **Fee:** $293.85 **Benefit:** 75% = $220.40 85% = $249.80 **Fee:** $372.00 **Benefit:** 75% = $279.00 85% = $316.20
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) **Fee:** $94.50 **Benefit:** 75% = $70.90 85% = $80.35
30680	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $1,148.20 **Benefit:** 75% = $861.15 85% = $1,074.50
30682	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: - have recurrent or persistent bleeding; and - 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 T8.17 of explanatory notes to this Category)* **Fee:** $1,148.20 **Benefit:** 75% = $861.15 85% = $1,074.50
30684	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: - have recurrent or persistent bleeding; and - 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 T8.17 of explanatory notes to this Category)* **Fee:** $1,413.00 **Benefit:** 75% = $1,059.75 85% = $1,339.30

30686	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (snare polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: - have recurrent or persistent bleeding; and - 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 T8.17 of explanatory notes to this Category)* **Fee:** $1,413.00 **Benefit:** 75% = $1,059.75 85% = $1,339.30
30688	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $358.10 **Benefit:** 75% = $268.60 85% = $304.40
30690	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $552.80 **Benefit:** 75% = $414.60 85% = $479.10
30692	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $358.10 **Benefit:** 75% = $268.60 85% = $304.40
30694	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.17 and T8.21 of explanatory notes to this Category)* **Fee:** $552.80 **Benefit:** 75% = $414.60 85% = $479.10
30696	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 not being a service associated with another item in this subgroup or to which items 30710 and 55054 apply (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $552.80 **Benefit:** 75% = $414.60 85% = $479.10
30710	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.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $552.80 **Benefit:** 75% = $414.60 85% = $479.10
31000	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes.) **Fee:** $570.05 **Benefit:** 75% = $427.55 85% = $496.35

31001	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes.) **Fee:** $712.50 **Benefit:** 75% = $534.40 85% = $638.80
31002	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes.) **Fee:** $855.05 **Benefit:** 75% = $641.30 85% = $781.35
31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service associated with a service to which item 45200, 45203 or 45206 applies and not being a service to which another item in this Group applies *(See para T8.22 of explanatory notes to this Category)* **Fee:** $33.35 **Benefit:** 75% = $25.05 85% = $28.35
31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter**, **removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $93.65 **Benefit:** 75% = $70.25 85% = $79.65
31210	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 10mm and up to and including 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $120.80 **Benefit:** 75% = $90.60 85% = $102.70
31215	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $140.85 **Benefit:** 75% = $105.65 85% = $119.75
31220	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter, removal of 4 to 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $210.55 **Benefit:** 75% = $157.95 85% = $179.00
31225	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to and including 10mm in diameter, removal of more than 10 lesions by surgical excision (other than by shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimens excised are sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $374.20 **Benefit:** 75% = $280.65 85% = $318.10
31230	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from nose, eyelid, lip, ear, digit or genitalia, *including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $164.90 **Benefit:** 75% = $123.70 85% = $140.20

31235	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to and including 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $140.85 **Benefit:** 75% = $105.65 85% = $119.75
31240	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision (other than by shave excision) and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $164.90 **Benefit:** 75% = $123.70 85% = $140.20
31245	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $362.10 **Benefit:** 75% = $271.60 85% = $307.80
31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface ***where the specimen excised is sent for histological confirmation of diagnosis*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $362.10 **Benefit:** 75% = $271.60 85% = $307.80
31255	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter -** where removal is by therapeutic **surgical excision (other than by shave excision) and suture and** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $217.20 **Benefit:** 75% = $162.90 85% = $184.65
31256	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where previous excision was performed by the same practitioner***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $217.20 **Benefit:** 75% = $162.90 85% = $184.65
31257	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $217.20 **Benefit:** 75% = $162.90 85% = $184.65
31258	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and where** ***the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $217.20 **Benefit:** 75% = $162.90 85% = $184.65
31260	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **therapeutic surgical excision (other than shave excision) and suture** ***and where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $309.75 **Benefit:** 75% = $232.35 85% = $263.30

31261	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *where previous excision was performed by the same practitioner*, where the original tumour size was more than 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $309.75 **Benefit:** 75% = $232.35 85% = $263.30
31262	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *where performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was more than 10mm in diameter*** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $309.75 **Benefit:** 75% = $232.35 85% = $263.30
31263	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from nose, eyelid, lip, ear, digit or genitalia, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is more than 10mm in diameter*** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained* - not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $309.75 **Benefit:** 75% = $232.35 85% = $263.30
31265	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
31266	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), *where previous excision was performed by the same practitioner*, where the original tumour size was up to and including 10mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
31267	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), *where performed by a practitioner other than the practitioner who provided the previous treatment, where the original tumour size was up to and including 10mm in diameter*** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
31268	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment, where the tumour size is up to and including 10mm in diameter*** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained* - not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
31270	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck, (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.45 **Benefit:** 75% = $190.10 85% = $215.45

31271	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.45 **Benefit:** 75% = $190.10 85% = $215.45
31272	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.45 **Benefit:** 75% = $190.10 85% = $215.45
31273	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 10mm and up to and including 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $253.45 **Benefit:** 75% = $190.10 85% = $215.45
31275	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $293.65 **Benefit:** 75% = $220.25 85% = $249.65
31276	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where previous excision was performed by the same practitioner***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $293.65 **Benefit:** 75% = $220.25 85% = $249.65
31277	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***where performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $293.65 **Benefit:** 75% = $220.25 85% = $249.65
31278	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** **- not being a service to which item 31295 applies** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $293.65 **Benefit:** 75% = $220.25 85% = $249.65
31280	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items** ***31255*** **and** ***31265*****, tumour size up to and including 10mm in diameter** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture,** ***where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $152.95 **Benefit:** 75% = $114.75 85% = $130.05

31281	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*, *where previous excision was performed by the same practitioner*, <u>where the original tumour size was up to and including 10mm in diameter</u>** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $153.50 **Benefit:** 75% = $115.15 85% = $130.50
31282	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items *31255* and *31265*, *performed by a practitioner other than the practitioner who provided the previous treatment*, <u>where the original tumour size was up to and including 10mm in diameter</u>** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $153.50 **Benefit:** 75% = $115.15 85% = $130.50
31283	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items *31255* and *31265*, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, <u>where the tumour size is up to and including 10mm in diameter</u>** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $153.50 **Benefit:** 75% = $115.15 85% = $130.50
31285	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, <u>tumour size more than 10mm and up to and including 20mm in diameter</u>** and where removal is by therapeutic **surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $209.00 **Benefit:** 75% = $156.75 85% = $177.65
31286	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *where previous excision was performed by the same practitioner*, <u>where the original tumour size was more than 10mm and up to and including 20mm in diameter</u>** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $209.00 **Benefit:** 75% = $156.75 85% = $177.65
31287	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31270, *performed by a practitioner other than the practitioner who provided the previous treatment*, <u>where the original tumour size was more than 10mm and up to and including 20mm in diameter</u>** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $209.00 **Benefit:** 75% = $156.75 85% = $177.65
31288	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31270, *whether previous excision was performed by the same practitioner* OR *performed by a practitioner other than the practitioner who provided the previous treatment*, <u>where the tumour size is more than 10mm and up to and including 20mm in diameter</u>** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $209.00 **Benefit:** 75% = $156.75 85% = $177.65
31290	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275*, <u>tumour size more than 20mm in diameter</u>** and where removal is by **therapeutic surgical excision (other than by shave excision) and suture, *where the initial specimen removed is sent for histological examination and malignancy confirmed, and any subsequently excised specimen is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $241.30 **Benefit:** 75% = $181.00 85% = $205.15
31291	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275, *where previous excision was performed by the same practitioner*, <u>where the original tumour size was more than 20mm in diameter</u>** and where removal is by **surgical excision (other than by shave excision) and suture and *where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $241.30 **Benefit:** 75% = $181.00 85% = $205.15

31292	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RESIDUAL, removal of, **from areas of the body not covered by items 31260 and 31275,** ***performed by a practitioner other than the practitioner who provided the previous treatment***, **where the original tumour size was more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $241.30 **Benefit:** 75% = $181.00 85% = $205.15
31293	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT, removal of, **from areas of the body not covered by items 31260 and 31275,** ***whether previous excision was performed by the same practitioner*** **OR** ***performed by a practitioner other than the practitioner who provided the previous treatment,*** **where the tumour size is more than 20mm in diameter** and where removal is by **surgical excision (other than by shave excision) and suture and** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $241.30 **Benefit:** 75% = $181.00 85% = $205.15
31295	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, RECURRENT (where lesion was treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), ***performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment***, **removal from the head or neck (anterior to the sternomastoid muscles)**, where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $287.40 **Benefit:** 75% = $215.55 85% = $244.30
	TREATMENT OF MALIGNANT MELANOMA AND LOCALLY AGGRESSIVE SKIN TUMOURS Definitive surgical excision for items 31300-31335 is defined as "surgical removal with an adequate margin and as a result, no further surgery is indicated at that site of excision".
31300	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $313.95 **Benefit:** 75% = $235.50 85% = $266.90
31305	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE and **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $386.15 **Benefit:** 75% = $289.65 85% = $328.25
31310	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $273.45 **Benefit:** 75% = $205.10 85% = $232.45
31315	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $345.95 **Benefit:** 75% = $259.50 85% = $294.10

31320	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 and T8.23 of explanatory notes to this Category)* **Fee:** $386.15 **Benefit:** 75% = $289.65 85% = $328.25
31325	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31300* and *31310* - tumour size up to and including 10mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $265.50 **Benefit:** 75% = $199.15 85% = $225.70
31330	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31310* - tumour size more than 10mm and up to and including 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $313.95 **Benefit:** 75% = $235.50 85% = $266.90
31335	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - tumour size more than 20mm in diameter** and where removal is by **definitive surgical excision (as defined above and in the explanatory notes to this category) and suture, *where the specimen excised is sent for histological examination and confirmation of malignancy has been obtained*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $362.10 **Benefit:** 75% = $271.60 85% = $307.80
31340	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item.* MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, where the specimen excised is sent for histological confirmation, performed in association with excision of malignant tumour of skin covered by item **31255, 31256, 31257, 31258, 31260, 31261, 31262, 31263, 31265, 31266, 31267, 31268, 31270, 31271, 31272, 31273, 31275, 31276, 31277, 31278, 31280, 31281, 31282, 31283, 31285, 31286, 31287, 31288, 31290, 31291, 31292, 31293, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Derived Fee:** 75% of the fee for excision of malignant tumour
31345	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and **50mm or more in diameter**, or is sub-fascial, ***where the specimen is sent for histological confirmation of diagnosis*** (Anaes.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $207.00 **Benefit:** 75% = $155.25 85% = $175.95
31346	LIPOSUCTION (suction assisted lipolysis) to 1 regional area for treatment of contour problems of abdominal or upper arm or thigh fat due to repeated insulin injections, ***where the lesion is subcutaneous and 50mm or more in diameter*** (Anaes.) **Fee:** $207.00 **Benefit:** 75% = $155.25 85% = $175.95
31350	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by **surgical excision**, ***where the specimen excised is sent for histological confirmation of diagnosis***, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $425.25 **Benefit:** 75% = $318.95 85% = $361.50
31355	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by **surgical excision**, where ***histological proof of malignancy has been obtained***, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $701.15 **Benefit:** 75% = $525.90 85% = $627.45
31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $217.80

31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to and including 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $295.75 **Benefit:** 75% = $221.85
31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.) **Fee:** $492.80 **Benefit:** 75% = $369.60 85% = $419.10
31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,531.05 **Benefit:** 75% = $1,148.30
31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) **Fee:** $1,885.90 **Benefit:** 75% = $1,414.45
31420	LYMPH NODE OF NECK, biopsy of (Anaes.) **Fee:** $180.45 **Benefit:** 75% = $135.35 85% = $153.40
31423	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $394.25 **Benefit:** 75% = $295.70 85% = $335.15
31426	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $788.45 **Benefit:** 75% = $591.35
31429	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,228.75 **Benefit:** 75% = $921.60
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,314.20 **Benefit:** 75% = $985.65
31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $965.95 **Benefit:** 75% = $724.50
31438	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $1,531.05 **Benefit:** 75% = $1,148.30
31441	(*see Item 14215 for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band*) LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes.) **Fee:** $247.00 **Benefit:** 75% = $185.25 85% = $209.95
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.) **Fee:** $399.05 **Benefit:** 75% = $299.30
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.) **Fee:** $698.25 **Benefit:** 75% = $523.70
31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.) **Fee:** $240.95 **Benefit:** 75% = $180.75

31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $289.15 **Benefit:** 75% = $216.90
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) **Fee:** $350.35 **Benefit:** 75% = $262.80
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
31464	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $855.05 **Benefit:** 75% = $641.30
31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.) *(See para T8.20 of explanatory notes to this Category)* **Fee:** $1,282.60 **Benefit:** 75% = $961.95
31468	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.) **Fee:** $1,409.10 **Benefit:** 75% = $1,056.85
31470	LAPAROSCOPIC SPLENECTOMY (Anaes.) (Assist.) **Fee:** $706.75 **Benefit:** 75% = $530.10
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) **Fee:** $1,148.00 **Benefit:** 75% = $861.00
31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $255.20 **Benefit:** 75% = $191.40 85% = $216.95
31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30
31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $382.85 **Benefit:** 75% = $287.15
31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30
31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $638.05 **Benefit:** 75% = $478.55
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $428.00 **Benefit:** 75% = $321.00
31518	BREAST (female), total mastectomy (Anaes.) (Assist.) **Fee:** $722.55 **Benefit:** 75% = $541.95
31521	BREAST (male), total mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $425.40 **Benefit:** 75% = $319.05 85% = $361.60

31524	BREAST (female), subcutaneous mastectomy (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $1,020.85 **Benefit:** 75% = $765.65
31527	BREAST (male), subcutaneous mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $510.50 **Benefit:** 75% = $382.90 85% = $436.80
31530	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated: (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 **Fee:** $584.55 **Benefit:** 75% = $438.45 85% = $510.85
31533	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $135.35 **Benefit:** 75% = $101.55 85% = $115.05
31536	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.) **Fee:** $185.85 **Benefit:** 75% = $139.40 85% = $158.00
31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using advanced breast biopsy instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.) *(See para T8.28 of explanatory notes to this Category)* **Fee:** $391.35 **Benefit:** 75% = $293.55
31542	BREAST, initial guidewire localisation of lesion, by hookwire or similar device, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to advanced breast biopsy instrumentation (ABBI), - including imaging not being a service associated with a service to which item 31536 applies (Anaes.) *(See para T8.29 of explanatory notes to this Category)* **Fee:** $193.30 **Benefit:** 75% = $145.00 85% = $164.35
31545	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using advanced breast biopsy instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.) *(See para T8.28 of explanatory notes to this Category)* **Fee:** $584.55 **Benefit:** 75% = $438.45 85% = $510.85
31548	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.) **Fee:** $135.35 **Benefit:** 75% = $101.55 85% = $115.05
31551	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $212.70 **Benefit:** 75% = $159.55 85% = $180.80
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.) **Fee:** $425.40 **Benefit:** 75% = $319.05
31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.) **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30
31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.) **Fee:** $340.30 **Benefit:** 75% = $255.25 85% = $289.30
31563	INVERTED NIPPLE, surgical eversion of (Anaes.) **Fee:** $254.90 **Benefit:** 75% = $191.20 85% = $216.70

31566	ACCESSORY NIPPLE, excision of (Anaes.) **Fee:** $127.55 **Benefit:** 75% = $95.70 85% = $108.45
	SUBGROUP 2 - COLORECTAL
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,012.10 **Benefit:** 75% = $759.10
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.) **Fee:** $1,058.70 **Benefit:** 75% = $794.05
32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,128.90 **Benefit:** 75% = $846.70
32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.) **Fee:** $1,275.30 **Benefit:** 75% = $956.50
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.) **Fee:** $1,128.90 **Benefit:** 75% = $846.70
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.) **Fee:** $1,339.15 **Benefit:** 75% = $1,004.40
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) **Fee:** $1,479.30 **Benefit:** 75% = $1,109.50
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) **Fee:** $1,817.95 **Benefit:** 75% = $1,363.50
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) **Fee:** $1,541.55 **Benefit:** 75% = $1,156.20
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,339.15 **Benefit:** 75% = $1,004.40
32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,791.25 **Benefit:** 75% = $1,343.45
32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.) **Fee:** $1,929.00 **Benefit:** 75% = $1,446.75
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) **Fee:** $2,066.95 **Benefit:** 75% = $1,550.25
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $413.35 **Benefit:** 75% = $310.05
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) **Fee:** $1,012.10 **Benefit:** 75% = $759.10
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) **Fee:** $1,479.30 **Benefit:** 75% = $1,109.50

32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) **Fee:** $1,876.15 **Benefit:** 75% = $1,407.15
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) **Fee:** $1,506.45 **Benefit:** 75% = $1,129.85
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) **Fee:** $1,269.05 **Benefit:** 75% = $951.80
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) **Fee:** $474.95 **Benefit:** 75% = $356.25
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) **Fee:** $733.95 **Benefit:** 75% = $550.50
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) **Fee:** $855.05 **Benefit:** 75% = $641.30
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,273.40 **Benefit:** 75% = $1,705.05
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,086.55 **Benefit:** 75% = $1,564.95
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.) **Fee:** $2,273.40 **Benefit:** 75% = $1,705.05
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $2,086.55 **Benefit:** 75% = $1,564.95
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) **Fee:** $1,681.70 **Benefit:** 75% = $1,261.30
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $46.95 **Benefit:** 75% = $35.25 85% = $39.95
32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $73.65 **Benefit:** 75% = $55.25 85% = $62.65
32078	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (Anaes.) **Fee:** $165.40 **Benefit:** 75% = $124.05 85% = $140.60
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.) **Fee:** $227.15 **Benefit:** 75% = $170.40 85% = $193.10
32084	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $109.25 **Benefit:** 75% = $81.95 85% = $92.90

32087	Endoscopic examination of the colon up to the hepatic flexure by FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of, not being a service to which item 32078 applies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $200.90 **Benefit:** 75% = $150.70 85% = $170.80
32090	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $328.10 **Benefit:** 75% = $246.10 85% = $278.90
32093	Endoscopic examination of the colon beyond the hepatic flexure by FIBREOPTIC COLONOSCOPY for the REMOVAL OF 1 OR MORE POLYPS, or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by ARGON PLASMA COAGULATION, 1 or more of (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $460.45 **Benefit:** 75% = $345.35 85% = $391.40
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $541.55 **Benefit:** 75% = $406.20
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $125.40 **Benefit:** 75% = $94.05 85% = $106.60
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital (Anaes.) (Assist.) **Fee:** $252.15 **Benefit:** 75% = $189.15 85% = $214.35
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $327.00 **Benefit:** 75% = $245.25
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (Anaes.) (Assist.) **Fee:** $622.85 **Benefit:** 75% = $467.15
32103	RECTAL TUMOUR, of less than 4cm in diameter, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy or by local excision not being a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.) *(See para T8.17 and T8.30 of explanatory notes to this Category)* **Fee:** $757.90 **Benefit:** 75% = $568.45
32104	RECTAL TUMOUR, of 4cm or greater in diameter, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy or by local excision not being a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.) *(See para T8.17 and T8.30 of explanatory notes to this Category)* **Fee:** $981.00 **Benefit:** 75% = $735.75
32105	ANORECTAL CARCINOMA per anal full thickness excision of (Anaes.) (Assist.) **Fee:** $474.95 **Benefit:** 75% = $356.25 85% = $403.75
32106	ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy and where removal requires dissection within the peritoneal cavity not being a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.) *(See para T8.17 and T8.30 of explanatory notes to this Category)* **Fee:** $1,339.15 **Benefit:** 75% = $1,004.40 85% = $1,265.45
32108	RECTAL TUMOUR, transsphincteric excision of (Kraske or similar operation) (Anaes.) (Assist.) **Fee:** $981.00 **Benefit:** 75% = $735.75
32111	RECTAL PROLAPSE Delorme procedure for (Anaes.) (Assist.) **Fee:** $622.85 **Benefit:** 75% = $467.15

32112	RECTAL PROLAPSE, perineal recto-sigmoidectomy for (Anaes.) (Assist.) **Fee:** $757.90 **Benefit:** 75% = $568.45
32114	RECTAL STRICTURE, per anal release of (Anaes.) **Fee:** $171.20 **Benefit:** 75% = $128.40 85% = $145.55
32115	RECTAL STRICTURE, dilatation of (Anaes.) **Fee:** $124.50 **Benefit:** 75% = $93.40
32117	RECTAL PROLAPSE, abdominal rectopexy of (Anaes.) (Assist.) **Fee:** $981.00 **Benefit:** 75% = $735.75
32120	RECTAL PROLAPSE, perineal repair of (Anaes.) (Assist.) **Fee:** $252.15 **Benefit:** 75% = $189.15
32123	ANAL STRICTURE, anoplasty for (Anaes.) (Assist.) **Fee:** $327.00 **Benefit:** 75% = $245.25 85% = $277.95
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (Anaes.) (Assist.) **Fee:** $474.95 **Benefit:** 75% = $356.25
32129	ANAL SPHINCTER, direct repair of (Anaes.) (Assist.) **Fee:** $622.85 **Benefit:** 75% = $467.15
32131	RECTOCELE, transanal repair of rectocele (Anaes.) (Assist.) **Fee:** $523.65 **Benefit:** 75% = $392.75
32132	HAEMORRHOIDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.) **Fee:** $44.25 **Benefit:** 75% = $33.20 85% = $37.65
32135	HAEMORRHOIDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, cryotherapy or infra red therapy for (Anaes.) **Fee:** $66.25 **Benefit:** 75% = $49.70 85% = $56.35
32138	HAEMORRHOIDECTOMY including excision of anal skin tags when performed (Anaes.) **Fee:** $360.90 **Benefit:** 75% = $270.70 85% = $306.80
32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes.) (Assist.) **Fee:** $360.90 **Benefit:** 75% = $270.70
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (Anaes.) **Fee:** $66.25 **Benefit:** 75% = $49.70 85% = $56.35
32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $132.55 **Benefit:** 75% = $99.45 85% = $112.70
32147	PERIANAL THROMBOSIS, incision of (Anaes.) **Fee:** $44.25 **Benefit:** 75% = $33.20 85% = $37.65
32150	OPERATION FOR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) **Fee:** $252.15 **Benefit:** 75% = $189.15 85% = $214.35
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $68.80 **Benefit:** 75% = $51.60
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) **Fee:** $129.30 **Benefit:** 75% = $97.00 85% = $109.95
32159	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $327.00 **Benefit:** 75% = $245.25
32162	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $474.95 **Benefit:** 75% = $356.25

32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) **Fee:** $622.85 **Benefit:** 75% = $467.15 85% = $549.15
32166	ANAL FISTULA - readjustment of Seton (Anaes.) **Fee:** $202.35 **Benefit:** 75% = $151.80 85% = $172.00
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) **Fee:** $129.30 **Benefit:** 75% = $97.00
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $87.15 **Benefit:** 75% = $65.40
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) **Fee:** $87.15 **Benefit:** 75% = $65.40 85% = $74.10
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital (excluding aftercare) (Anaes.) **Fee:** $159.60 **Benefit:** 75% = $119.70
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $171.00 **Benefit:** 75% = $128.25
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) **Fee:** $252.15 **Benefit:** 75% = $189.15
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) **Fee:** $551.20 **Benefit:** 75% = $413.40
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) **Fee:** $551.20 **Benefit:** 75% = $413.40
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65 85% = $246.70
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) **Fee:** $623.15 **Benefit:** 75% = $467.40
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) **Fee:** $563.00 **Benefit:** 75% = $422.25
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) **Fee:** $904.75 **Benefit:** 75% = $678.60
32210	GRACILIS NEOSPHINCTER PACEMAKER, replacement of (Anaes.) **Fee:** $250.70 **Benefit:** 75% = $188.05 85% = $213.10
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital, excluding aftercare (Anaes.) **Fee:** $133.70 **Benefit:** 75% = $100.30 85% = $113.65
32213	SACRAL NERVE LEAD(S), placement of, percutaneous using fluoroscopic guidance, or open, and intraoperative test stimulation, for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment (Anaes.) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $648.65 **Benefit:** 75% = $486.50
32214	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of faecal incontinence in a patient who has an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, using fluoroscopic guidance (Anaes.) (Assist.) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $327.75 **Benefit:** 75% = $245.85

32215	SACRAL NERVE ELECTRODE(S), management, adjustment, and electronic programming of neurostimulator by a medical practitioner, for the management of faecal incontinence - each day *(See para T8.31 of explanatory notes to this Category)* **Fee:** $123.05 **Benefit:** 75% = $92.30 85% = $104.60
32216	SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, surgical repositioning of, percutaneous using fluoroscopic guidance, or open, to correct displacement or unsatisfactory positioning, and intraoperative test stimulation, not being a service to which item 32213 applies (Anaes.) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $582.50 **Benefit:** 75% = $436.90
32217	NEUROSTIMULATOR or RECEIVER, inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $153.40 **Benefit:** 75% = $115.05
32218	SACRAL NERVE LEAD(S), inserted for the management of faecal incontinence in a patient who had an anatomically intact but functionally deficient anal sphincter with faecal incontinence refractory to at least 12 months of conservative non-surgical treatment, removal of (Anaes.) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $153.40 **Benefit:** 75% = $115.05
32220	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed (Anaes.) (Assist.) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $887.05 **Benefit:** 75% = $665.30 85% = $813.35
32221	Removal or revision of an artificial bowel sphincter (with or without replacement) for severe faecal incontinence in the treatment of a patient for whom conservative and other less invasive forms of treatment are contraindicated or have failed (Anaes.) (Assist.) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $887.05 **Benefit:** 75% = $665.30 85% = $813.35
	SUBGROUP 3 - VASCULAR
	VARICOSE VEINS
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60 **Extended Medicare Safety Net Cap:** $119.30
32501	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg, (excluding after-care) where it can be demonstrated that truncal reflux in the long or short saphenous veins has been excluded by duplex examination ***- and that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period*** *(See para T8.33 of explanatory notes to this Category)* **Fee:** $107.75 **Benefit:** 75% = $80.85 85% = $91.60
32504	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $262.65 **Benefit:** 75% = $197.00 85% = $223.30
32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $523.65 **Benefit:** 75% = $392.75 85% = $449.95

32508	VARICOSE VEINS, complete dissection at the sapheno-femoral **OR** sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $523.65 **Benefit:** 75% = $392.75
32511	VARICOSE VEINS, complete dissection at the sapheno-femoral **AND** sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $778.50 **Benefit:** 75% = $583.90
32514	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $909.50 **Benefit:** 75% = $682.15
32517	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $1,171.15 **Benefit:** 75% = $878.40
32520	VARICOSE VEINS, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, including all preparation and immediate clinical aftercare but not including radiofrequency diathermy or radiofrequency ablation. (Anaes.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $523.65 **Benefit:** 75% = $392.75 85% = $449.95 **Extended Medicare Safety Net Cap:** $76.35
32522	VARICOSE VEINS, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, including all preparation and immediate clinical aftercare but not including radiofrequency diathermy or radiofrequency ablation. (Anaes.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $778.50 **Benefit:** 75% = $583.90 85% = $704.80 **Extended Medicare Safety Net Cap:** $76.35
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,409.50 **Benefit:** 75% = $1,057.15
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) **Fee:** $1,394.85 **Benefit:** 75% = $1,046.15
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) **Fee:** $1,549.85 **Benefit:** 75% = $1,162.40
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.) **Fee:** $1,704.85 **Benefit:** 75% = $1,278.65
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,232.40 **Benefit:** 75% = $924.30
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) **Fee:** $1,232.40 **Benefit:** 75% = $924.30
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55

32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) **Fee:** $1,852.15 **Benefit:** 75% = $1,389.15
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) **Fee:** $2,103.15 **Benefit:** 75% = $1,577.40
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,594.00 **Benefit:** 75% = $1,195.50
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) **Fee:** $1,852.15 **Benefit:** 75% = $1,389.15
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) **Fee:** $405.85 **Benefit:** 75% = $304.40
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.) **Fee:** $1,269.30 **Benefit:** 75% = $952.00
32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.) **Fee:** $1,453.90 **Benefit:** 75% = $1,090.45
32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.) **Fee:** $1,660.40 **Benefit:** 75% = $1,245.30
32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.) **Fee:** $1,800.60 **Benefit:** 75% = $1,350.45
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55
32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.) **Fee:** $1,453.90 **Benefit:** 75% = $1,090.45
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.) **Fee:** $405.85 **Benefit:** 75% = $304.40
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) **Fee:** $774.95 **Benefit:** 75% = $581.25
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.) **Fee:** $268.55 **Benefit:** 75% = $201.45
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) **Fee:** $1,428.15 **Benefit:** 75% = $1,071.15

33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) **Fee:** $1,145.30 **Benefit:** 75% = $859.00
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $826.30 **Benefit:** 75% = $619.75 85% = $752.60
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,051.10 **Benefit:** 75% = $788.35
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,283.05 **Benefit:** 75% = $962.30
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,409.50 **Benefit:** 75% = $1,057.15 85% = $1,335.80
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $1,977.70 **Benefit:** 75% = $1,483.30
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,391.05 **Benefit:** 75% = $1,793.30 85% = $2,317.35
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) **Fee:** $2,073.70 **Benefit:** 75% = $1,555.30
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) **Fee:** $1,394.85 **Benefit:** 75% = $1,046.15
33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,372.90 **Benefit:** 75% = $1,029.70 85% = $1,299.20
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.) **Fee:** $1,549.85 **Benefit:** 75% = $1,162.40
33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.) **Fee:** $1,525.55 **Benefit:** 75% = $1,144.20 85% = $1,451.85
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $1,704.85 **Benefit:** 75% = $1,278.65
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90 85% = $1,483.45
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) **Fee:** $1,357.85 **Benefit:** 75% = $1,018.40
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) **Fee:** $1,018.30 **Benefit:** 75% = $763.75
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) **Fee:** $2,567.95 **Benefit:** 75% = $1,926.00
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) **Fee:** $1,453.90 **Benefit:** 75% = $1,090.45 85% = $1,380.20

33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,501.65 **Benefit:** 75% = $1,876.25
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $3,106.75 **Benefit:** 75% = $2,330.10
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,951.80 **Benefit:** 75% = $2,213.85
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) **Fee:** $2,184.40 **Benefit:** 75% = $1,638.30
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) **Fee:** $2,435.25 **Benefit:** 75% = $1,826.45
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) **Fee:** $2,435.25 **Benefit:** 75% = $1,826.45
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) **Fee:** $2,066.45 **Benefit:** 75% = $1,549.85
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) **Fee:** $2,066.45 **Benefit:** 75% = $1,549.85 85% = $1,992.75
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) **Fee:** $1,608.80 **Benefit:** 75% = $1,206.60
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,254.50 **Benefit:** 75% = $940.90
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,156.15 **Benefit:** 75% = $867.15
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,470.25 **Benefit:** 75% = $1,102.70
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) **Fee:** $1,797.55 **Benefit:** 75% = $1,348.20
	ENDARTERECTOMY AND ARTERIAL PATCH
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.) **Fee:** $1,114.25 **Benefit:** 75% = $835.70
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $1,247.20 **Benefit:** 75% = $935.40
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) **Fee:** $1,394.85 **Benefit:** 75% = $1,046.15
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.) **Fee:** $1,549.85 **Benefit:** 75% = $1,162.40
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.) **Fee:** $1,704.85 **Benefit:** 75% = $1,278.65

33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) **Fee:** $1,247.20 **Benefit:** 75% = $935.40 85% = $1,173.50
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) **Fee:** $1,350.45 **Benefit:** 75% = $1,012.85
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,594.00 **Benefit:** 75% = $1,195.50
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) **Fee:** $1,852.15 **Benefit:** 75% = $1,389.15
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,594.00 **Benefit:** 75% = $1,195.50
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) **Fee:** $1,852.15 **Benefit:** 75% = $1,389.15
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,321.00 **Benefit:** 75% = $990.75
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) **Fee:** $951.95 **Benefit:** 75% = $714.00
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) **Fee:** $1,357.85 **Benefit:** 75% = $1,018.40
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $268.55 **Benefit:** 75% = $201.45
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $546.20 **Benefit:** 75% = $409.65
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $268.55 **Benefit:** 75% = $201.45
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) **Fee:** $267.30 **Benefit:** 75% = $200.50
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) **Fee:** $1,158.60 **Benefit:** 75% = $868.95 85% = $1,084.90
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) **Fee:** $1,107.00 **Benefit:** 75% = $830.25
33806	EMBOLECTOMY OR THROMBECTOMY, including the infusion of thrombolytic or other agents, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (Anaes.) (Assist.) *(See para T8.38 of explanatory notes to this Category)* **Fee:** $797.00 **Benefit:** 75% = $597.75 85% = $723.30
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) **Fee:** $581.40 **Benefit:** 75% = $436.05 85% = $507.70
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) **Fee:** $1,730.90 **Benefit:** 75% = $1,298.20

33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) **Fee:** $915.05 **Benefit:** 75% = $686.30 85% = $841.35
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $841.30 **Benefit:** 75% = $631.00
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $981.50 **Benefit:** 75% = $736.15
33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,121.70 **Benefit:** 75% = $841.30
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) **Fee:** $1,070.00 **Benefit:** 75% = $802.50
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,254.50 **Benefit:** 75% = $940.90
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) **Fee:** $1,438.95 **Benefit:** 75% = $1,079.25
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) **Fee:** $1,306.35 **Benefit:** 75% = $979.80
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) **Fee:** $1,822.75 **Benefit:** 75% = $1,367.10
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) **Fee:** $900.30 **Benefit:** 75% = $675.25
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $627.30 **Benefit:** 75% = $470.50
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) **Fee:** $627.30 **Benefit:** 75% = $470.50
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) **Fee:** $693.80 **Benefit:** 75% = $520.35
34103	GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $405.85 **Benefit:** 75% = $304.40
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes.) (Assist.) **Fee:** $286.25 **Benefit:** 75% = $214.70 85% = $243.35
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) **Fee:** $332.05 **Benefit:** 75% = $249.05 85% = $282.25

34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) **Fee:** $841.30 **Benefit:** 75% = $631.00
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) **Fee:** $951.95 **Benefit:** 75% = $714.00
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) **Fee:** $1,357.85 **Benefit:** 75% = $1,018.40 85% = $1,284.15
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,084.75 **Benefit:** 75% = $813.60
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,188.20 **Benefit:** 75% = $891.15
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) **Fee:** $487.05 **Benefit:** 75% = $365.30 85% = $414.00
34133	SCALENOTOMY (Anaes.) (Assist.) **Fee:** $546.20 **Benefit:** 75% = $409.65
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) **Fee:** $878.05 **Benefit:** 75% = $658.55
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $878.05 **Benefit:** 75% = $658.55
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) **Fee:** $1,084.75 **Benefit:** 75% = $813.60
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) **Fee:** $789.65 **Benefit:** 75% = $592.25
34148	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.) **Fee:** $1,409.50 **Benefit:** 75% = $1,057.15
34151	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.) **Fee:** $1,926.05 **Benefit:** 75% = $1,444.55
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) **Fee:** $2,295.15 **Benefit:** 75% = $1,721.40 85% = $2,221.45
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,184.40 **Benefit:** 75% = $1,638.30
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) **Fee:** $2,804.25 **Benefit:** 75% = $2,103.20
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) **Fee:** $2,804.25 **Benefit:** 75% = $2,103.20
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90

34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) **Fee:** $1,269.30 **Benefit:** 75% = $952.00
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55
	OPERATIONS FOR VASCULAR ACCESS
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) **Fee:** $302.65 **Benefit:** 75% = $227.00 85% = $257.30
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $405.85 **Benefit:** 75% = $304.40
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) **Fee:** $206.55 **Benefit:** 75% = $154.95
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) **Fee:** $959.30 **Benefit:** 75% = $719.50
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) **Fee:** $1,055.35 **Benefit:** 75% = $791.55
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) **Fee:** $752.70 **Benefit:** 75% = $564.55
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) **Fee:** $1,261.80 **Benefit:** 75% = $946.35
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) **Fee:** $775.20 **Benefit:** 75% = $581.40
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) **Fee:** $405.85 **Benefit:** 75% = $304.40
34527	CENTRAL VEIN CATHETERISATION by <u>open technique</u>, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes.) **Fee:** $541.30 **Benefit:** 75% = $406.00 85% = $467.60
34528	CENTRAL VEIN CATHETERISATION by <u>percutaneous technique</u>, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes.) **Fee:** $267.30 **Benefit:** 75% = $200.50 85% = $227.25
34530	HICKMAN OR BROVIAC CATHETER, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital or approved day-hospital (Anaes.) **Fee:** $200.45 **Benefit:** 75% = $150.35 85% = $170.40
34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.) **Fee:** $1,217.50 **Benefit:** 75% = $913.15 85% = $1,143.80
34538	CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) **Fee:** $267.30 **Benefit:** 75% = $200.50 85% = $227.25
34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital (Anaes.) **Fee:** $200.45 **Benefit:** 75% = $150.35 85% = $170.40

	COMPLEX VENOUS OPERATIONS
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) **Fee:** $797.00 **Benefit:** 75% = $597.75 85% = $723.30
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) **Fee:** $1,756.50 **Benefit:** 75% = $1,317.40
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) **Fee:** $951.95 **Benefit:** 75% = $714.00
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) **Fee:** $951.95 **Benefit:** 75% = $714.00
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.) **Fee:** $1,151.20 **Benefit:** 75% = $863.40
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $951.95 **Benefit:** 75% = $714.00
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) **Fee:** $1,047.90 **Benefit:** 75% = $785.95
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) **Fee:** $1,424.40 **Benefit:** 75% = $1,068.30 85% = $1,350.70
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) **Fee:** $487.05 **Benefit:** 75% = $365.30
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) **Fee:** $590.45 **Benefit:** 75% = $442.85
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) **Fee:** $693.80 **Benefit:** 75% = $520.35 85% = $620.10
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) **Fee:** $900.30 **Benefit:** 75% = $675.25
	SYMPATHECTOMY
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $693.80 **Benefit:** 75% = $520.35 85% = $620.10
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) **Fee:** $900.30 **Benefit:** 75% = $675.25
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) **Fee:** $1,129.10 **Benefit:** 75% = $846.85
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) **Fee:** $878.05 **Benefit:** 75% = $658.55
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) **Fee:** $693.80 **Benefit:** 75% = $520.35
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.) **Fee:** $361.70 **Benefit:** 75% = $271.30

35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $195.70
	MISCELLANEOUS VASCULAR PROCEDURES
35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes.) **Fee:** $168.30 **Benefit:** 75% = $126.25
35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.) **Fee:** $801.85 **Benefit:** 75% = $601.40
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
35300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $505.75 **Benefit:** 75% = $379.35 85% = $432.05
35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $648.50 **Benefit:** 75% = $486.40 85% = $574.80
35306	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $598.55 **Benefit:** 75% = $448.95 85% = $524.85
35307	TRANSLUMINAL STENT INSERTION, 1 or more stents (not drug-eluting), with or without associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or without the use of an embolic protection device, in patients who: - meet the indications for carotid endarterectomy; and - have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $1,100.25 **Benefit:** 75% = $825.20
35309	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $748.15 **Benefit:** 75% = $561.15 85% = $674.45
35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $847.95 **Benefit:** 75% = $636.00
35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $847.95 **Benefit:** 75% = $636.00
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) *(See para T8.40 of explanatory notes to this Category)* **Fee:** $349.15 **Benefit:** 75% = $261.90 85% = $296.80
35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $625.90 **Benefit:** 75% = $469.45 85% = $552.20

35320	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) **Fee:** $840.75 **Benefit:** 75% = $630.60 85% = $767.05
35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $798.15 **Benefit:** 75% = $598.65 85% = $724.45
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $299.25 **Benefit:** 75% = $224.45
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $401.10 **Benefit:** 75% = $300.85
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $505.75 **Benefit:** 75% = $379.35 85% = $432.05
35331	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.) **Fee:** $581.40 **Benefit:** 75% = $436.05
35360	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $812.75 **Benefit:** 75% = $609.60
35361	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $697.05 **Benefit:** 75% = $522.80
35362	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $581.40 **Benefit:** 75% = $436.05
35363	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare *(**foreign body** does not include an instrument inserted for the purpose of a service being rendered)* (Anaes.) (Assist.) **Fee:** $465.80 **Benefit:** 75% = $349.35
	INTERVENTIONAL RADIOLOGY PROCEDURES
35404	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiation therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies The procedure must be performed by a specialist or consultant physician recognised in the specialties of nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in the patient's lifetime only. *(See para T8.42 of explanatory notes to this Category)* **Fee:** $340.15 **Benefit:** 75% = $255.15

35406	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $798.15 **Benefit:** 75% = $598.65
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer SIR-Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal cancer and are not suitable for resection or ablation, for selective internal radiation therapy used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to which item 35317, 35319, 35320 or 35321 applies excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $598.70 **Benefit:** 75% = $449.05
35410	UTERINE ARTERY CATHETERISATION with percutaneous administration of occlusive agents, for the treatment of symptomatic uterine fibroids in a patient who has been referred for uterine artery embolisation by a specialist gynaecologist, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.35 of explanatory notes to this Category)* **Fee:** $798.15 **Benefit:** 75% = $598.65 85% = $724.45
35412	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion with detachable coils, and assisted coiling if performed, with parent artery preservation, not for use with liquid embolics only, including intra-operative imaging, but in association with pre-operative diagnostic imaging items 60009 and either 60072, 60075 or 60078, including aftercare (Anaes.) (Assist.) *(See para T8.36 of explanatory notes to this Category)* **Fee:** $2,804.25 **Benefit:** 75% = $2,103.20 85% = $2,730.55
	SUBGROUP 4 - GYNAECOLOGICAL
35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $79.80 **Benefit:** 75% = $59.85 85% = $67.85
35502	INTRAUTERINE DEVICE, INTRODUCTION OF, for the control of idiopathic menorrhagia, AND ENDOMETRIAL BIOPSY to exclude endometrial pathology, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $78.65 **Benefit:** 75% = $59.00 85% = $66.90
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $52.55 **Benefit:** 75% = $39.45 85% = $44.70
35506	INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $52.70 **Benefit:** 75% = $39.55 85% = $44.80
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) **Fee:** $171.20 **Benefit:** 75% = $128.40 85% = $145.55
35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) (Assist.) **Fee:** $252.15 **Benefit:** 75% = $189.15 85% = $214.35
35509	HYMENECTOMY (Anaes.) **Fee:** $87.80 **Benefit:** 75% = $65.85 85% = $74.65
35512 G 35513 S	BARTHOLIN'S CYST, excision of (Anaes.) **Fee:** $176.05 **Benefit:** 75% = $132.05 85% = $149.65 **Fee:** $217.55 **Benefit:** 75% = $163.20 85% = $184.95
35516 G 35517 S	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.) **Fee:** $114.20 **Benefit:** 75% = $85.65 85% = $97.10 **Fee:** $143.30 **Benefit:** 75% = $107.50 85% = $121.85

35518	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in premenopausal women and at least 2cm in diameter in postmenopausal women, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) **Fee:** $203.95	**Benefit:** 75% = $153.00	85% = $173.40
35520	BARTHOLIN'S ABSCESS, incision of (Anaes.) **Fee:** $57.20	**Benefit:** 75% = $42.90	85% = $48.65
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.) **Fee:** $57.20	**Benefit:** 75% = $42.90	85% = $48.65
35526 G 35527 S	URETHRAL CARUNCLE, excision of (Anaes.) **Fee:** $114.20 **Fee:** $143.30	**Benefit:** 75% = $85.65 **Benefit:** 75% = $107.50	85% = $97.10 85% = $121.85
35530	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.) **Fee:** $264.80	**Benefit:** 75% = $198.60	
35533	VULVOPLASTY or LABIOPLASTY, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes.) **Fee:** $343.35	**Benefit:** 75% = $257.55	85% = $291.85
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.) **Fee:** $341.95	**Benefit:** 75% = $256.50	85% = $290.70
35539	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.) **Fee:** $267.85	**Benefit:** 75% = $200.90	85% = $227.70
35542	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.) (Assist.) **Fee:** $313.65	**Benefit:** 75% = $235.25	85% = $266.65
35545	COLPOSCOPICALLY DIRECTED CO^2 LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.) **Fee:** $180.20	**Benefit:** 75% = $135.15	85% = $153.20
35548	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.) **Fee:** $818.50	**Benefit:** 75% = $613.90	
35551	PELVIC LYMPH GLANDS, excision of (radical) (Anaes.) (Assist.) **Fee:** $671.15	**Benefit:** 75% = $503.40	
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) **Fee:** $42.70	**Benefit:** 75% = $32.05	85% = $36.30
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.) **Fee:** $210.50	**Benefit:** 75% = $157.90	85% = $178.95
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.) **Fee:** $671.15	**Benefit:** 75% = $503.40	
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.) **Fee:** $1,353.80	**Benefit:** 75% = $1,015.35	
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.) **Fee:** $1,111.50	**Benefit:** 75% = $833.65	
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) **Fee:** $513.10	**Benefit:** 75% = $384.85	
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) **Fee:** $671.15	**Benefit:** 75% = $503.40	
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (Anaes.) (Assist.) **Fee:** $389.85	**Benefit:** 75% = $292.40	

35568	SACROSPINOUS COLPOPEXY FOR MANAGEMENT OF UPPER VAGINAL PROLAPSE (Anaes.) (Assist.) **Fee:** $612.95 **Benefit:** 75% = $459.75
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (Anaes.) **Fee:** $157.85 **Benefit:** 75% = $118.40 85% = $134.20
35570	ANTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving repair of urethrocoele and cystocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $543.50 **Benefit:** 75% = $407.65
35571	POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving one or more of the following; repair of perineum, rectocoele or enterocoele) with or without mesh, not being a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $543.50 **Benefit:** 75% = $407.65
35572	COLPOTOMY not being a service to which another item in this Group applies (Anaes.) **Fee:** $121.50 **Benefit:** 75% = $91.15
35573	ANTERIOR AND POSTERIOR VAGINAL COMPARTMENT REPAIR by vaginal approach (involving both anterior and posterior compartment defects) with or without mesh, not being a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.) **Fee:** $815.40 **Benefit:** 75% = $611.55
35577	MANCHESTER (DONALD FOTHERGILL) OPERATION for genital prolapse, with or without mesh (Anaes.) (Assist.) **Fee:** $661.90 **Benefit:** 75% = $496.45
35578	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $661.90 **Benefit:** 75% = $496.45
35595	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCORPORATING THE FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENTS TO RECTOVAGINAL AND PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,133.45 **Benefit:** 75% = $850.10
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being a service to which item 37029, 37333 or 37336 applies (Anaes.) (Assist.) **Fee:** $671.15 **Benefit:** 75% = $503.40
35597	SACRAL COLPOPEXY, laparoscopic or open procedure where graft or mesh secured to vault, anterior and posterior compartment and to sacrum for correction of symptomatic upper vaginal vault prolapse (Anaes.) (Assist.) **Fee:** $1,445.75 **Benefit:** 75% = $1,084.35
35599	STRESS INCONTINENCE, sling operation for, with or without mesh or tape, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $661.90 **Benefit:** 75% = $496.45
35602	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $661.90 **Benefit:** 75% = $496.45
35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) **Fee:** $359.15 **Benefit:** 75% = $269.40 85% = $305.30
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (Anaes.) **Fee:** $62.80 **Benefit:** 75% = $47.10 85% = $53.40
35611	CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (Anaes.) **Fee:** $62.80 **Benefit:** 75% = $47.10 85% = $53.40
35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes.) (Assist.) **Fee:** $496.55 **Benefit:** 75% = $372.45 85% = $422.85

35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) **Fee:** $397.25 **Benefit:** 75% = $297.95
35614	EXAMINATION OF LOWER FEMALE GENITAL TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.) *(See para T8.44 of explanatory notes to this Category)* **Fee:** $62.70 **Benefit:** 75% = $47.05 85% = $53.30
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $52.70 **Benefit:** 75% = $39.55 85% = $44.80
35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave or thermal balloon or radiofrequency electrosurgery, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) **Fee:** $441.20 **Benefit:** 75% = $330.90
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35577 or 35578 applies (Anaes.) **Fee:** $170.45 **Benefit:** 75% = $127.85 85% = $144.90 **Fee:** $213.95 **Benefit:** 75% = $160.50 85% = $181.90
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) **Fee:** $52.35 **Benefit:** 75% = $39.30 85% = $44.50
35622	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.) **Fee:** $591.20 **Benefit:** 75% = $443.40
35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $803.95 **Benefit:** 75% = $603.00
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies *(See para T8.45 of explanatory notes to this Category)* **Fee:** $81.25 **Benefit:** 75% = $60.95 85% = $69.10
35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.) **Fee:** $105.15 **Benefit:** 75% = $78.90
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) **Fee:** $179.60 **Benefit:** 75% = $134.70 85% = $152.70
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.) **Fee:** $213.95 **Benefit:** 75% = $160.50 85% = $181.90
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) **Fee:** $672.90 **Benefit:** 75% = $504.70 85% = $599.20
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) **Fee:** $293.85 **Benefit:** 75% = $220.40
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) **Fee:** $424.95 **Benefit:** 75% = $318.75
35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.) **Fee:** $399.05 **Benefit:** 75% = $299.30

35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.) (Assist.) **Fee:** $698.25 **Benefit:** 75% = $523.70
35639 G 35640 S	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $132.40 **Benefit:** 75% = $99.30 **Fee:** $179.60 **Benefit:** 75% = $134.70
35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.) **Fee:** $1,219.50 **Benefit:** 75% = $914.65
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 or 35630 applies, where performed (Anaes.) **Fee:** $213.95 **Benefit:** 75% = $160.50 85% = $181.90
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (Anaes.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $199.85 **Benefit:** 75% = $149.90 85% = $169.90
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $312.75 **Benefit:** 75% = $234.60 85% = $265.85
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital (Anaes.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $199.85 **Benefit:** 75% = $149.90 85% = $169.90
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $199.85 **Benefit:** 75% = $149.90 85% = $169.90
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) *(See para T8.47 of explanatory notes to this Category)* **Fee:** $312.75 **Benefit:** 75% = $234.60 85% = $265.85
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.) **Fee:** $526.00 **Benefit:** 75% = $394.50
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $662.10 **Benefit:** 75% = $496.60
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $662.10 **Benefit:** 75% = $496.60

35658	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.) *(See para T8.49 of explanatory notes to this Category)* **Fee:** $408.30 **Benefit:** 75% = $306.25
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.) **Fee:** $855.05 **Benefit:** 75% = $641.30
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,425.10 **Benefit:** 75% = $1,068.85
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.) **Fee:** $1,211.25 **Benefit:** 75% = $908.45
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.) (Assist.) **Fee:** $997.35 **Benefit:** 75% = $748.05
35673	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.) **Fee:** $743.65 **Benefit:** 75% = $557.75
35674	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy **Fee:** $203.95 **Benefit:** 75% = $153.00 85% = $173.40
35676 G 35677 S	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.) **Fee:** $417.10 **Benefit:** 75% = $312.85 **Fee:** $526.00 **Benefit:** 75% = $394.50
35678	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.) **Fee:** $634.20 **Benefit:** 75% = $475.65
35680	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.) **Fee:** $571.20 **Benefit:** 75% = $428.40 85% = $497.50
35683 G 35684 S	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.) **Fee:** $344.75 **Benefit:** 75% = $258.60 **Fee:** $462.35 **Benefit:** 75% = $346.80
35687 G 35688 S	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method. **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $319.15 **Benefit:** 75% = $239.40 **Fee:** $389.85 **Benefit:** 75% = $292.40
35691	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explantory note before submitting a claim***. (Anaes.) (Assist.) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $155.75 **Benefit:** 75% = $116.85
35694	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.) **Fee:** $625.80 **Benefit:** 75% = $469.35

35697	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.) **Fee:** $928.55 **Benefit:** 75% = $696.45
35700	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (Anaes.) (Assist.) **Fee:** $716.45 **Benefit:** 75% = $537.35
35703	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure not being a service associated with a service to which another item in this Sub-group applies (Anaes.) **Fee:** $66.25 **Benefit:** 75% = $49.70 85% = $56.35
35706	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.) **Fee:** $66.25 **Benefit:** 75% = $49.70 85% = $56.35
35709	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.) **Fee:** $42.70 **Benefit:** 75% = $32.05 85% = $36.30
35710	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.) **Fee:** $454.65 **Benefit:** 75% = $341.00
35712 G 35713 S	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 1 such procedure, not being a service associated with hysterectomy (Anaes.) (Assist.) **Fee:** $355.40 **Benefit:** 75% = $266.55 **Fee:** $444.40 **Benefit:** 75% = $333.30
35716 G 35717 S	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes.) (Assist.) **Fee:** $426.25 **Benefit:** 75% = $319.70 **Fee:** $535.15 **Benefit:** 75% = $401.40
35720	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) *(See para T8.59 of explanatory notes to this Category)* **Fee:** $661.90 **Benefit:** 75% = $496.45
35723	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $474.10 **Benefit:** 75% = $355.60
35726	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.) **Fee:** $474.10 **Benefit:** 75% = $355.60
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.) **Fee:** $213.75 **Benefit:** 75% = $160.35
35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $769.95 **Benefit:** 75% = $577.50
35753	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $851.40 **Benefit:** 75% = $638.55
35754	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.) (Assist.) **Fee:** $1,071.55 **Benefit:** 75% = $803.70
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) **Fee:** $769.95 **Benefit:** 75% = $577.50

35759	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.) (Assist.) **Fee:** $552.80 **Benefit:** 75% = $414.60
	SUBGROUP 5 - UROLOGICAL
	GENERAL
36500	ADRENAL GLAND, excision of partial or total (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $671.15 **Benefit:** 75% = $503.40
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) **Fee:** $1,365.20 **Benefit:** 75% = $1,023.90
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) **Fee:** $768.35 **Benefit:** 75% = $576.30
36516	NEPHRECTOMY, complete (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,267.05 **Benefit:** 75% = $950.30
36522	NEPHRECTOMY, partial (Anaes.) (Assist.) **Fee:** $1,087.30 **Benefit:** 75% = $815.50
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,545.10 **Benefit:** 75% = $1,158.85
36526	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) *(See para T8.50 of explanatory notes to this Category)* **Fee:** $1,267.05 **Benefit:** 75% = $950.30 85% = $1,193.35
36527	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) *(See para T8.50 of explanatory notes to this Category)* **Fee:** $1,563.70 **Benefit:** 75% = $1,172.80 85% = $1,490.00
36528	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Anaes.) (Assist.) **Fee:** $1,267.05 **Benefit:** 75% = $950.30
36529	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Anaes.) (Assist.) **Fee:** $1,563.70 **Benefit:** 75% = $1,172.80
36531	NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,136.25 **Benefit:** 75% = $852.20
36532	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $1,630.85 **Benefit:** 75% = $1,223.15

36533	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Anaes.) (Assist.) **Fee:** $1,927.55 **Benefit:** 75% = $1,445.70
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $678.50 **Benefit:** 75% = $508.90
36540	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.) **Fee:** $1,087.30 **Benefit:** 75% = $815.50 85% = $1,013.60
36543	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) **Fee:** $1,267.05 **Benefit:** 75% = $950.30 85% = $1,193.35
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) **Fee:** $678.50 **Benefit:** 75% = $508.90 85% = $604.80
36549	URETEROLITHOTOMY (Anaes.) (Assist.) **Fee:** $817.55 **Benefit:** 75% = $613.20
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30 85% = $564.00
36561	RENAL BIOPSY (closed) (Anaes.) **Fee:** $169.30 **Benefit:** 75% = $127.00 85% = $143.95
36564	PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
36567	PYELOPLASTY in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Anaes.) (Assist.) **Fee:** $997.35 **Benefit:** 75% = $748.05
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.) **Fee:** $1,267.05 **Benefit:** 75% = $950.30
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
36576	KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.) (Assist.) **Fee:** $1,136.25 **Benefit:** 75% = $852.20
36579	URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) **Fee:** $1,087.30 **Benefit:** 75% = $815.50
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60

36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) **Fee:** $1,087.30 **Benefit:** 75% = $815.50 85% = $1,013.60
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) **Fee:** $1,267.05 **Benefit:** 75% = $950.30
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) **Fee:** $262.65 **Benefit:** 75% = $197.00 85% = $223.30
36605	URETERIC STENT, insertion of, with removal of calculus from: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $677.80 **Benefit:** 75% = $508.35
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) **Fee:** $2,272.60 **Benefit:** 75% = $1,704.45
36607	URETERIC STENT insertion of, with baloon dilatation of: (a) the pelvicalyceal system; or (b) ureter; or (c) the pelvicalyceal system and ureter; through a nephrostomy tube using interventional imaging techniques (Anaes.) **Fee:** $677.80 **Benefit:** 75% = $508.35
36608	URETERIC STENT, exchange of, percutaneously through either the ileal conduit or bladder, using interventional imaging techniques, not being a service associated with a service to which items 36811 to 36854 apply (Anaes.) **Fee:** $262.65 **Benefit:** 75% = $197.00
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30
36615	URETEROLYSIS, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) **Fee:** $455.85 **Benefit:** 75% = $341.90
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $547.70 **Benefit:** 75% = $410.80 85% = $474.00
36627	NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.) **Fee:** $678.50 **Benefit:** 75% = $508.90
36630	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $335.15 **Benefit:** 75% = $251.40
36633	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75 85% = $653.95

36636	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.) **Fee:** $392.45 **Benefit:** 75% = $294.35
36639	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.) **Fee:** $817.55 **Benefit:** 75% = $613.20
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) **Fee:** $408.70 **Benefit:** 75% = $306.55
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.) **Fee:** $1,046.40 **Benefit:** 75% = $784.80
36648	NEPHROSCOPY, being a service to which item 36645 applies, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (Anaes.) (Assist.) **Fee:** $931.90 **Benefit:** 75% = $698.95
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.) **Fee:** $262.65 **Benefit:** 75% = $197.00 85% = $223.30
36650	NEPHROSTOMY TUBE, removal of, if the ureter has been stented with a double J ureteric stent and that stent is left in place, using interventional imaging techniques (Anaes.) **Fee:** $146.90 **Benefit:** 75% = $110.20
36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803, 36812 or 36824 applies (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30
36654	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Assist.) **Fee:** $817.55 **Benefit:** 75% = $613.20
36656	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) **Fee:** $1,046.40 **Benefit:** 75% = $784.80
36658	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal of pulse generator and leads *(See para T8.51 of explanatory notes to this Category)* **Fee:** $516.60 **Benefit:** 75% = $387.45 85% = $442.90
36660	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of pulse generator *(See para T8.51 of explanatory notes to this Category)* **Fee:** $250.70 **Benefit:** 75% = $188.05 85% = $213.10
36662	SACRAL NERVE STIMULATION for refractory urinary incontinence or urge retention, removal and replacement of leads *(See para T8.51 of explanatory notes to this Category)* **Fee:** $598.90 **Benefit:** 75% = $449.20 85% = $525.20
	OPERATIONS ON BLADDER
36663	Sacral nerve lead(s), percutaneous placement using fluoroscopic guidance (or open placement) and intraoperative test stimulation, to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $648.65 **Benefit:** 75% = $486.50

36664	Sacral nerve lead(s), percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning) and intraoperative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older, not being a service to which item 36663 applies (Anaes.) **Fee:** $582.50 **Benefit:** 75% = $436.90
36665	Sacral nerve electrode or electrodes, management and adjustment of the pulse generator by a medical practitioner, to manage detrusor overactivity or non obstructive urinary retention – each day **Fee:** $123.05 **Benefit:** 75% = $92.30 85% = $104.60
36666	Pulse generator, subcutaneous placement of, and placement and connection of extension wire(s) to sacral nerve electrode(s), for the management of a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $327.75 **Benefit:** 75% = $245.85
36667	Sacral nerve lead(s), removal of, if the lead was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $153.40 **Benefit:** 75% = $115.05
36668	Pulse generator, removal of, if the pulse generator was inserted to manage: a) detrusor overactivity; or b) non obstructive urinary retention that has been refractory to at least 12 months medical and conservative treatment in a patient 18 years of age or older. (Anaes.) **Fee:** $153.40 **Benefit:** 75% = $115.05
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) **Fee:** $27.10 **Benefit:** 75% = $20.35 85% = $23.05
36803	URETEROSCOPY, of one ureter, with or without any one or more of; cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652, 36654, 36656, 36806, 36809, 36812, 36824, 36848 or 36857 applies (Anaes.) (Assist.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $457.65 **Benefit:** 75% = $343.25 85% = $389.05
36806	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30
36809	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 36824, 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) **Fee:** $817.55 **Benefit:** 75% = $613.20
36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes.) **Fee:** $317.35 **Benefit:** 75% = $238.05 85% = $269.75
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.) **Fee:** $163.60 **Benefit:** 75% = $122.70 85% = $139.10
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (Anaes.) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $233.45 **Benefit:** 75% = $175.10 85% = $198.45

36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
36821	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) **Fee:** $317.15 **Benefit:** 75% = $237.90 85% = $269.60
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.) **Fee:** $209.20 **Benefit:** 75% = $156.90 85% = $177.85
36825	CYSTOSCOPY, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818, 36821, 36824, 36830 or 36833 applies (Anaes.) (Assist.) **Fee:** $570.45 **Benefit:** 75% = $427.85
36827	CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes.) **Fee:** $225.55 **Benefit:** 75% = $169.20 85% = $191.75
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.) **Fee:** $199.45 **Benefit:** 75% = $149.60
36833	CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes.) (Assist.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206 or 37215 applies (Anaes.) **Fee:** $225.55 **Benefit:** 75% = $169.20 85% = $191.75
36840	CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 applies (Anaes.) **Fee:** $317.15 **Benefit:** 75% = $237.90 85% = $269.60
36842	CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, 36827 to 36863, 37203 or 37206 apply (Anaes.) (Assist.) **Fee:** $319.15 **Benefit:** 75% = $239.40
36845	CYSTOSCOPY, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.) **Fee:** $678.50 **Benefit:** 75% = $508.90 85% = $604.80
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) **Fee:** $225.55 **Benefit:** 75% = $169.20
36851	CYSTOSCOPY, with injection into bladder wall (Anaes.) **Fee:** $225.55 **Benefit:** 75% = $169.20
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) **Fee:** $457.65 **Benefit:** 75% = $343.25
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.) **Fee:** $359.60 **Benefit:** 75% = $269.70
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) **Fee:** $163.60 **Benefit:** 75% = $122.70 85% = $139.10
36863	LITHOLAPAXY, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $457.65 **Benefit:** 75% = $343.25
37000	BLADDER, partial excision of (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
37004	BLADDER, repair of rupture (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30

37008	CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes.) **Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40
37011	SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.) **Fee:** $91.60 **Benefit:** 75% = $68.70 85% = $77.90
37014	BLADDER, total excision of (Anaes.) (Assist.) **Fee:** $1,046.40 **Benefit:** 75% = $784.80
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) **Fee:** $408.70 **Benefit:** 75% = $306.55
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) **Fee:** $408.70 **Benefit:** 75% = $306.55
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) **Fee:** $678.85 **Benefit:** 75% = $509.15
37041	BLADDER ASPIRATION by needle **Fee:** $45.75 **Benefit:** 75% = $34.35 85% = $38.90
37042	BLADDER STRESS INCONTINENCE, sling procedure for, using autologous fascial sling, including harvesting of sling, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $894.30 **Benefit:** 75% = $670.75
37043	BLADDER STRESS INCONTINENCE, Stamey or similar type needle colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $661.90 **Benefit:** 75% = $496.45
37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $678.85 **Benefit:** 75% = $509.15
37045	MITROFANOFF CONTINENT VALVE, formation of (Anaes.) (Assist.) **Fee:** $1,402.10 **Benefit:** 75% = $1,051.60
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) **Fee:** $1,635.00 **Benefit:** 75% = $1,226.25
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) **Fee:** $840.75 **Benefit:** 75% = $630.60
	OPERATIONS ON PROSTATE
37200	PROSTATECTOMY, open (Anaes.) (Assist.) **Fee:** $997.35 **Benefit:** 75% = $748.05
37201	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) *(See para T8.55 of explanatory notes to this Category)* **Fee:** $813.40 **Benefit:** 75% = $610.05

37202	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 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.) *(See para T8.55 of explanatory notes to this Category)* **Fee:** $408.30 **Benefit:** 75% = $306.25 85% = $347.10
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,022.70 **Benefit:** 75% = $767.05
37206	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 or which had to be discontinued for medical reasons (Anaes.) **Fee:** $547.70 **Benefit:** 75% = $410.80
37207	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37321 or 37324 applies (Anaes.) **Fee:** $850.30 **Benefit:** 75% = $637.75
37208	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37201, 37203 or 37207 or which had to be discontinued for medical reasons (Anaes.) **Fee:** $408.30 **Benefit:** 75% = $306.25
37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.) **Fee:** $1,267.05 **Benefit:** 75% = $950.30
37210	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,563.70 **Benefit:** 75% = $1,172.80
37211	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, ***with pelvic lymphadenectomy***, not being a service associated with a service to which item 35551, 36502 or 37375 applies (Anaes.) (Assist.) **Fee:** $1,899.10 **Benefit:** 75% = $1,424.35
37212	PROSTATE, open perineal biopsy or open drainage of abscess (Anaes.) (Assist.) **Fee:** $271.45 **Benefit:** 75% = $203.60
37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.) **Fee:** $408.70 **Benefit:** 75% = $306.55 85% = $347.40
37217	Prostate, implantation of gold fiducial markers into the prostate gland or prostate surgical bed (Anaes.) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $135.70 **Benefit:** 75% = $101.80 85% = $115.35
37218	PROSTATE, needle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.) **Fee:** $135.70 **Benefit:** 75% = $101.80 85% = $115.35
37219	PROSTATE, transrectal needle biopsy of, using transrectal prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) (Assist.) **Fee:** $275.60 **Benefit:** 75% = $206.70 85% = $234.30
37220	PROSTATE, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. (Anaes.) *(See para T8.57 of explanatory notes to this Category)* **Fee:** $1,024.75 **Benefit:** 75% = $768.60
37221	PROSTATIC ABSCESS, endoscopic drainage of (Anaes.) (Assist.) **Fee:** $457.65 **Benefit:** 75% = $343.25

37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) **Fee:** $202.40 **Benefit:** 75% = $151.80
37224	PROSTATE, diathermy or visual laser destruction of lesion of, not being a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.) **Fee:** $317.15 **Benefit:** 75% = $237.90 85% = $269.60
37227	PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15331 or 15332 applies. (Anaes.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $555.30 **Benefit:** 75% = $416.50 85% = $481.60
37230	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37203, 37206, 37207, 37208, 37303, 37321 or 37324 applies (Anaes.) **Fee:** $1,022.70 **Benefit:** 75% = $767.05 85% = $949.00
37233	PROSTATE, high-energy transurethral microwave thermotherapy of, with or without cystoscopy and with or without urethroscopy and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203, 37207, 37230 which had to be discontinued for medical reasons (Anaes.) **Fee:** $547.70 **Benefit:** 75% = $410.80 85% = $474.00
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) **Fee:** $45.75 **Benefit:** 75% = $34.35 85% = $38.90
37303	URETHRAL STRICTURE, dilatation of (Anaes.) **Fee:** $72.65 **Benefit:** 75% = $54.50 85% = $61.80
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
37315	URETHROSCOPY, as an independent procedure (Anaes.) **Fee:** $135.70 **Benefit:** 75% = $101.80 85% = $115.35
37318	URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) **Fee:** $91.60 **Benefit:** 75% = $68.70 85% = $77.90
37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.) **Fee:** $225.55 **Benefit:** 75% = $169.20
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) **Fee:** $317.15 **Benefit:** 75% = $237.90
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) **Fee:** $637.70 **Benefit:** 75% = $478.30
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $547.70 **Benefit:** 75% = $410.80
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
37339	PERIURETHRAL OR TRANSURETHRAL INJECTION of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.) **Fee:** $235.40 **Benefit:** 75% = $176.55 85% = $200.10

37340	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Anaes.) (Assist.) **Fee:** $417.10 **Benefit:** 75% = $312.85
37341	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.) (Assist.) **Fee:** $894.30 **Benefit:** 75% = $670.75
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) **Fee:** $817.55 **Benefit:** 75% = $613.20
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.) **Fee:** $1,365.20 **Benefit:** 75% = $1,023.90
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) **Fee:** $678.50 **Benefit:** 75% = $508.90
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) **Fee:** $678.50 **Benefit:** 75% = $508.90
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $271.45 **Benefit:** 75% = $203.60
37354	HYPOSPADIAS, meatotomy and hemicircumcision (Anaes.) (Assist.) **Fee:** $317.15 **Benefit:** 75% = $237.90
37369	URETHRA, excision of prolapse of (Anaes.) **Fee:** $183.10 **Benefit:** 75% = $137.35
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) **Fee:** $457.65 **Benefit:** 75% = $343.25
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) **Fee:** $1,136.25 **Benefit:** 75% = $852.20
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) **Fee:** $1,136.25 **Benefit:** 75% = $852.20
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) **Fee:** $317.15 **Benefit:** 75% = $237.90
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
37393	PRIAPISM, decompression by glanular stab cavernosospongiosum shunt or penile aspiration with or without lavage (Anaes.) **Fee:** $225.55 **Benefit:** 75% = $169.20 85% = $191.75
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75
37402	PENIS, partial amputation of (Anaes.) (Assist.) **Fee:** $457.65 **Benefit:** 75% = $343.25
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) **Fee:** $457.65 **Benefit:** 75% = $343.25

37411	PENIS, repair of avulsion (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60 85% = $833.75
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months **Fee:** $45.75 **Benefit:** 75% = $34.35 85% = $38.90
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.) **Fee:** $547.70 **Benefit:** 75% = $410.80
37418	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Anaes.) (Assist.) **Fee:** $727.65 **Benefit:** 75% = $545.75 85% = $653.95
37420	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes.) (Assist.) **Fee:** $359.60 **Benefit:** 75% = $269.70
37423	PENIS, lengthening by translocation of corpora (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) **Fee:** $956.40 **Benefit:** 75% = $717.30
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) **Fee:** $317.15 **Benefit:** 75% = $237.90
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) **Fee:** $91.60 **Benefit:** 75% = $68.70 85% = $77.90
37438	SCROTUM, partial excision of (Anaes.) (Assist.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.) **Fee:** $981.00 **Benefit:** 75% = $735.75 85% = $907.30
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
37604	EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
37605	TRANSCUTANEOUS SPERM RETRIEVAL, unilateral, from either the testis or the epididymis, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, excluding a service to which item 13218 applies. (Anaes.) *(See para T8.60 of explanatory notes to this Category)* **Fee:** $366.50 **Benefit:** 75% = $274.90 85% = $311.55
37606	OPEN SURGICAL SPERM RETRIEVAL, unilateral, including the exploration of scrotal contents, with our without biopsy, for the purposes of INTRACYTOPLASMIC SPERM INJECTION, in a man with male factor infertility, performed in a hospital, excluding a service to which item 13218 or 37604 applies. (Anaes.) *(See para T8.61 of explanatory notes to this Category)* **Fee:** $544.20 **Benefit:** 75% = $408.15 85% = $470.50
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.) **Fee:** $907.45 **Benefit:** 75% = $680.60
37610	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes.) (Assist.) **Fee:** $1,365.20 **Benefit:** 75% = $1,023.90

37613	EPIDIDYMECTOMY (Anaes.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $678.50 **Benefit:** 75% = $508.90
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) **Fee:** $271.45 **Benefit:** 75% = $203.60 85% = $230.75
37622 G 37623 S	VASOTOMY OR VASECTOMY, unilateral or bilateral **NOTE:** ***Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe the explanatory note before submitting a claim***. (Anaes.) *(See para T8.48 of explanatory notes to this Category)* **Fee:** $189.60 **Benefit:** 75% = $142.20 85% = $161.20 **Fee:** $225.55 **Benefit:** 75% = $169.20 85% = $191.75
	PAEDIATRIC GENITURINARY SURGERY
37800	PATENT URACHUS, excision of (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.) (Assist.) **Fee:** $591.00 **Benefit:** 75% = $443.25 85% = $517.30
37809	UNDESCENDED TESTIS, revision orchidopexy for (Anaes.) (Assist.) **Fee:** $591.00 **Benefit:** 75% = $443.25
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 applies (Anaes.) (Assist.) **Fee:** $545.65 **Benefit:** 75% = $409.25
37815	HYPOSPADIAS, examination under anaesthesia with erection test (Anaes.) **Fee:** $91.00 **Benefit:** 75% = $68.25
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement (Anaes.) (Assist.) **Fee:** $482.30 **Benefit:** 75% = $361.75 85% = $410.00
37821	HYPOSPADIAS, distal, 1 stage repair (Anaes.) (Assist.) **Fee:** $817.55 **Benefit:** 75% = $613.20
37824	HYPOSPADIAS, proximal, 1 stage repair (Anaes.) (Assist.) **Fee:** $1,136.70 **Benefit:** 75% = $852.55
37827	HYPOSPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $523.65 **Benefit:** 75% = $392.75
37830	HYPOSPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $678.50 **Benefit:** 75% = $508.90 85% = $604.80
37833	HYPOSPADIAS, repair of post operative urethral fistula (Anaes.) (Assist.) **Fee:** $323.80 **Benefit:** 75% = $242.85
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) **Fee:** $682.05 **Benefit:** 75% = $511.55
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) **Fee:** $772.90 **Benefit:** 75% = $579.70

37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) **Fee:** $1,500.60 **Benefit:** 75% = $1,125.45
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.) **Fee:** $682.05 **Benefit:** 75% = $511.55
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) **Fee:** $1,227.70 **Benefit:** 75% = $920.80
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) **Fee:** $909.50 **Benefit:** 75% = $682.15
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.) **Fee:** $359.60 **Benefit:** 75% = $269.70
	SUBGROUP 6 - CARDIO-THORACIC
	CARDIOLOGY PROCEDURES
38200	RIGHT HEART CATHETERISATION, with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $437.10 **Benefit:** 75% = $327.85 85% = $371.55
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $521.65 **Benefit:** 75% = $391.25 85% = $447.95
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure with any one or more of the following: fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection or exercise stress test (Anaes.) **Fee:** $630.65 **Benefit:** 75% = $473.00 85% = $556.95
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $809.75 **Benefit:** 75% = $607.35 85% = $736.05
38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $1,346.85 **Benefit:** 75% = $1,010.15 85% = $1,273.15
38213	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.) **Fee:** $401.10 **Benefit:** 75% = $300.85 85% = $340.95
38215	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $348.30 **Benefit:** 75% = $261.25 85% = $296.10
38218	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $522.35 **Benefit:** 75% = $391.80 85% = $448.65

38220	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $174.10 **Benefit:** 75% = $130.60 85% = $148.00
38222	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $348.30 **Benefit:** 75% = $261.25 85% = $296.10
38225	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $522.40 **Benefit:** 75% = $391.80 85% = $448.70
38228	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $696.65 **Benefit:** 75% = $522.50 85% = $622.95
38231	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $870.70 **Benefit:** 75% = $653.05 85% = $797.00
38234	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $696.50 **Benefit:** 75% = $522.40 85% = $622.80
38237	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $870.65 **Benefit:** 75% = $653.00 85% = $796.95
38240	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $1,044.75 **Benefit:** 75% = $783.60 85% = $971.05
38241	USE OF A CORONARY PRESSURE WIRE during selective coronary angiography to measure fractional flow reserve (FFR) and coronary flow reserve (CFR) in one or more intermediate coronary artery or graft lesions (stenosis of 30-70%), to determine whether revascularisation should be performed where previous stress testing has either not been performed or the results are inconlclusive (Anaes.) **Fee:** $460.95 **Benefit:** 75% = $345.75 85% = $391.85
38243	PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $435.35 **Benefit:** 75% = $326.55 85% = $370.05

38246	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.) *(See para T8.54 of explanatory notes to this Category)* **Fee:** $870.65 **Benefit:** 75% = $653.00 85% = $796.95
38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.) **Fee:** $262.25 **Benefit:** 75% = $196.70 85% = $222.95
38270	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.) **Fee:** $895.30 **Benefit:** 75% = $671.50 85% = $821.60
38272	ATRIAL SEPTAL DEFECT closure, with septal occluder or other similar device, by transcatheter approach (Anaes.) (Assist.) **Fee:** $895.30 **Benefit:** 75% = $671.50 85% = $821.60
38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.) **Fee:** $292.65 **Benefit:** 75% = $219.50 85% = $248.80
38285	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where: - 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. including initial programming and testing, as an admitted patient in an approved hospital (Anaes.) *(See para T8.63 of explanatory notes to this Category)* **Fee:** $189.30 **Benefit:** 75% = $142.00 85% = $160.95
38286	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.) **Fee:** $170.50 **Benefit:** 75% = $127.90 85% = $144.95
	CATHETER BASED ARRHYTHMIA ABLATION
38287	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.) **Fee:** $2,059.30 **Benefit:** 75% = $1,544.50 85% = $1,985.60
38290	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.) **Fee:** $2,622.15 **Benefit:** 75% = $1,966.65
38293	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.) **Fee:** $2,814.55 **Benefit:** 75% = $2,110.95 85% = $2,740.85
	ENDOVASCULAR INTERVENTIONAL PROCEDURES
38300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) **Fee:** $505.75 **Benefit:** 75% = $379.35 85% = $432.05
38303	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.) **Fee:** $648.50 **Benefit:** 75% = $486.40 85% = $574.80
38306	TRANSLUMINAL INSERTION OF STENT OR STENTS into 1 occlusional site, including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.64 of explanatory notes to this Category)* **Fee:** $748.15 **Benefit:** 75% = $561.15 85% = $674.45

38309	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $868.95 **Benefit:** 75% = $651.75 85% = $795.25
38312	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,111.25 **Benefit:** 75% = $833.45 85% = $1,037.55
38315	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,193.20 **Benefit:** 75% = $894.90 85% = $1,119.50
38318	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,556.75 **Benefit:** 75% = $1,167.60 85% = $1,483.05
	MISCELLANEOUS CARDIAC PROCEDURES
38350	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $626.75 **Benefit:** 75% = $470.10
38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of, not for cardiac resynchronisation therapy, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $250.70 **Benefit:** 75% = $188.05
38356	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) *(See para T8.62 of explanatory notes to this Category)* **Fee:** $821.75 **Benefit:** 75% = $616.35
38358	Extraction of chronically implanted transvenous pacing or defibrillator lead or leads, by percutaneous method where the leads have been in situ for greater than six months and require removal with locking stylets, snares and/or extraction sheaths in a facility where cardiac surgery is available, in association with item 61109 or 60509 (Anaes.) (Assist.) *(See para T8.66 of explanatory notes to this Category)* **Fee:** $2,814.55 **Benefit:** 75% = $2,110.95
38359	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) **Fee:** $131.05 **Benefit:** 75% = $98.30 85% = $111.40
38362	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) **Fee:** $377.75 **Benefit:** 75% = $283.35 85% = $321.10

38365	PERMANENT CARDIAC SYNCRONISATION DEVICE, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) *(See para T8.65 of explanatory notes to this Category)* **Fee:** $250.70 **Benefit:** 75% = $188.05
38368	PERMANENT TRANSVENOUS LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of through the coronary sinus, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. Where the service includes right heart catheterisation and any associated venogram of left ventricular veins. Not being a service associated with a service to which items 38200 and 35200 apply (Anaes.) *(See para T8.65 of explanatory notes to this Category)* **Fee:** $1,201.75 **Benefit:** 75% = $901.35
38371	PERMANENT CARDIAC SYNCHRONISATION DEVICE CAPABLE OF DEFIBRILLATION, insertion, removal or replacement of, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) *(See para T8.67 of explanatory notes to this Category)* **Fee:** $282.50 **Benefit:** 75% = $211.90 85% = $240.15
38384	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,033.00 **Benefit:** 75% = $774.75 85% = $959.30
38387	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for, primary prevention of sudden cardiac death in: - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after a myocardial infarct when the patient has received optimised medical therapy; or - patients with chronic heart failure associated with mild to moderate symptoms (NYHA II and III) and a left ventricular ejection fraction less than or equal to 35% when the patient has received optimised medical therapy. Not being a service associated with a service to which item 38213 applies, not for defibrillators capable of cardiac resynchronisation therapy (Anaes.) (Assist.) **Fee:** $282.50 **Benefit:** 75% = $211.90 85% = $240.15
38390	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) **Fee:** $1,033.00 **Benefit:** 75% = $774.75 85% = $959.30
38393	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of for - not for patients with heart failure or as primary prevention for tachycardia arrhythmias. Not being a service associated with a service to which item 38213 applies. (Anaes.) (Assist.) **Fee:** $282.50 **Benefit:** 75% = $211.90 85% = $240.15
	THORACIC SURGERY
38415	EMPYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.) **Fee:** $391.90 **Benefit:** 75% = $293.95 85% = $333.15

38418	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.) **Fee:** $940.55 **Benefit:** 75% = $705.45
38421	THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.) **Fee:** $1,503.45 **Benefit:** 75% = $1,127.60
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.) **Fee:** $940.55 **Benefit:** 75% = $705.45
38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.) **Fee:** $1,161.35 **Benefit:** 75% = $871.05
38430	THORACOPLASTY (in stages) each stage (Anaes.) (Assist.) **Fee:** $598.55 **Benefit:** 75% = $448.95
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) **Fee:** $245.10 **Benefit:** 75% = $183.85
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.) **Fee:** $1,503.45 **Benefit:** 75% = $1,127.60
38440	LUNG, wedge resection of (Anaes.) (Assist.) **Fee:** $1,125.80 **Benefit:** 75% = $844.35
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.) **Fee:** $1,781.35 **Benefit:** 75% = $1,336.05
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.) **Fee:** $1,161.35 **Benefit:** 75% = $871.05
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,503.45 **Benefit:** 75% = $1,127.60
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.) **Fee:** $356.30 **Benefit:** 75% = $267.25
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,103.25 **Benefit:** 75% = $1,577.45
38450	PERICARDIUM, transthoracic open surgical drainage of (Anaes.) (Assist.) **Fee:** $840.70 **Benefit:** 75% = $630.55
38452	PERICARDIUM, sub-xyphoid drainage of (Anaes.) (Assist.) **Fee:** $563.00 **Benefit:** 75% = $422.25
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $1,688.80 **Benefit:** 75% = $1,266.60
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) **Fee:** $2,284.30 **Benefit:** 75% = $1,713.25
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,503.45 **Benefit:** 75% = $1,127.60
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.) **Fee:** $1,403.60 **Benefit:** 75% = $1,052.70
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.) **Fee:** $748.15 **Benefit:** 75% = $561.15
38460	STERNAL WIRE OR WIRES, removal of (Anaes.) **Fee:** $270.25 **Benefit:** 75% = $202.70

38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.) **Fee:** $320.35 **Benefit:** 75% = $240.30
38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.) **Fee:** $348.20 **Benefit:** 75% = $261.15
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.) **Fee:** $940.15 **Benefit:** 75% = $705.15
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.) **Fee:** $1,448.65 **Benefit:** 75% = $1,086.50
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.) **Fee:** $1,688.80 **Benefit:** 75% = $1,266.60
	CARDIAC SURGERY PROCEDURES
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $940.55 **Benefit:** 75% = $705.45
38473	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $563.00 **Benefit:** 75% = $422.25
	VALVULAR PROCEDURES
38475	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $816.25 **Benefit:** 75% = $612.20
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,966.00 **Benefit:** 75% = $1,474.50
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $952.30 **Benefit:** 75% = $714.25
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,966.00 **Benefit:** 75% = $1,474.50
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,238.15 **Benefit:** 75% = $1,678.65
38483	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,688.80 **Benefit:** 75% = $1,266.60
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $801.85 **Benefit:** 75% = $601.40
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,688.80 **Benefit:** 75% = $1,266.60

38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,874.00 **Benefit:** 75% = $1,405.50
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,228.70 **Benefit:** 75% = $1,671.55
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $544.20 **Benefit:** 75% = $408.15
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,921.10 **Benefit:** 75% = $1,440.85
	SURGERY FOR ISCHAEMIC HEART DISEASE
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $612.30 **Benefit:** 75% = $459.25
38497	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service asociated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.) *(See para T8.69 and T8.70 of explanatory notes to this Category)* **Fee:** $2,009.40 **Benefit:** 75% = $1,507.05
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.) *(See para T8.69 and T8.70 of explanatory notes to this Category)* **Fee:** $2,009.40 **Benefit:** 75% = $1,507.05
38500	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.) *(See para T8.69 and T8.70 of explanatory notes to this Category)* **Fee:** $2,159.00 **Benefit:** 75% = $1,619.25
38501	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.) *(See para T8.69 and T8.70 of explanatory notes to this Category)* **Fee:** $2,159.00 **Benefit:** 75% = $1,619.25
38503	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.) *(See para T8.69 and T8.70 of explanatory notes to this Category)* **Fee:** $2,344.15 **Benefit:** 75% = $1,758.15
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, **performed without cardiopulmonary bypass**, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.) *(See para T8.69 and T8.70 of explanatory notes to this Category)* **Fee:** $2,344.15 **Benefit:** 75% = $1,758.15
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $272.10 **Benefit:** 75% = $204.10

38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,595.95 **Benefit:** 75% = $1,197.00
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,873.60 **Benefit:** 75% = $1,405.20
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,344.15 **Benefit:** 75% = $1,758.15
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,344.15 **Benefit:** 75% = $1,758.15
	ARRHYTHMIA SURGERY
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,059.30 **Benefit:** 75% = $1,544.50
38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,622.15 **Benefit:** 75% = $1,966.65
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,814.55 **Benefit:** 75% = $2,110.95
	PROCEDURES ON THORACIC AORTA
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,106.15 **Benefit:** 75% = $1,579.65
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,669.05 **Benefit:** 75% = $2,001.80
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $3,046.80 **Benefit:** 75% = $2,285.10
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,483.80 **Benefit:** 75% = $1,862.85
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $3,046.80 **Benefit:** 75% = $2,285.10
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $3,417.30 **Benefit:** 75% = $2,563.00

38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endvascular means (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,828.20 **Benefit:** 75% = $1,371.15
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,013.50 **Benefit:** 75% = $1,510.15
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,950.00 **Benefit:** 75% = $1,462.50
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $544.20 **Benefit:** 75% = $408.15
	TECHNIQUES FOR PRESERVATION OF ARRESTED HEART
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $408.30 **Benefit:** 75% = $306.25
	CIRCULATORY SUPPORT PROCEDURES
38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,503.45 **Benefit:** 75% = $1,127.60
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $940.55 **Benefit:** 75% = $705.45
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $470.20 **Benefit:** 75% = $352.65
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $527.10 **Benefit:** 75% = $395.35 85% = $453.40
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $661.50 **Benefit:** 75% = $496.15
38615	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,503.45 **Benefit:** 75% = $1,127.60
38618	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,874.00 **Benefit:** 75% = $1,405.50
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $748.15 **Benefit:** 75% = $561.15
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $840.70 **Benefit:** 75% = $630.55

38627	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $657.10 **Benefit:** 75% = $492.85
	RE-OPERATION
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $544.20 **Benefit:** 75% = $408.15
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.) *(See para T8.69 and T8.71 of explanatory notes to this Category)* **Fee:** $940.55 **Benefit:** 75% = $705.45
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCEDURES
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,047.50 **Benefit:** 75% = $785.65
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,874.00 **Benefit:** 75% = $1,405.50
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,874.00 **Benefit:** 75% = $1,405.50
38654	PERMANENT LEFT VENTRICULAR ELECTRODE, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for patients who have moderate to severe chronic heart failure (NYHA class III or IV) despite optimised medical therapy and who meet all of the following criteria: - sinus rhythm - a left ventricular ejection fraction of less than or equal to 35% - a QRS duration greater than or equal to 120ms. (Anaes.) (Assist.) *(See para T8.65 and T8.69 of explanatory notes to this Category)* **Fee:** $1,201.75 **Benefit:** 75% = $901.35
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $940.55 **Benefit:** 75% = $705.45
	CARDIAC TUMOURS
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,873.60 **Benefit:** 75% = $1,405.20
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,108.80 **Benefit:** 75% = $1,581.60
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,972.85 **Benefit:** 75% = $1,479.65

38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.) **Fee:** $2,340.10 **Benefit:** 75% = $1,755.10 85% = $2,266.40
	CONGENITAL CARDIAC SURGERY
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,047.50 **Benefit:** 75% = $785.65
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,888.20 **Benefit:** 75% = $1,416.15
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,788.40 **Benefit:** 75% = $1,341.30
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,515.35 **Benefit:** 75% = $1,886.55
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,674.50 **Benefit:** 75% = $1,255.90
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,467.90 **Benefit:** 75% = $1,100.95
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,467.90 **Benefit:** 75% = $1,100.95
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,467.90 **Benefit:** 75% = $1,100.95
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05

38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,888.20 **Benefit:** 75% = $1,416.15
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $1,888.20 **Benefit:** 75% = $1,416.15
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38751	VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,622.15 **Benefit:** 75% = $1,966.65
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) *(See para T8.69 of explanatory notes to this Category)* **Fee:** $2,094.70 **Benefit:** 75% = $1,571.05
	MISCELLANEOUS PROCEDURES ON THE CHEST
38800	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38803 applies **Fee:** $37.80 **Benefit:** 75% = $28.35 85% = $32.15
38803	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $75.45 **Benefit:** 75% = $56.60 85% = $64.15
38806	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $131.05 **Benefit:** 75% = $98.30 85% = $111.40
38809	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) **Fee:** $161.50 **Benefit:** 75% = $121.15 85% = $137.30
38812	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) **Fee:** $205.25 **Benefit:** 75% = $153.95 85% = $174.50
	SUBGROUP 7 - NEUROSURGICAL
	GENERAL
39000	LUMBAR PUNCTURE (Anaes.) **Fee:** $73.90 **Benefit:** 75% = $55.45 85% = $62.85
39003	CISTERNAL PUNCTURE (Anaes.) **Fee:** $84.05 **Benefit:** 75% = $63.05 85% = $71.45

39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.) **Fee:** $156.45 **Benefit:** 75% = $117.35 85% = $133.00
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.) **Fee:** $58.25 **Benefit:** 75% = $43.70
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) **Fee:** $233.15 **Benefit:** 75% = $174.90
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.) **Fee:** $107.10 **Benefit:** 75% = $80.35 85% = $91.05
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.) **Fee:** $369.00 **Benefit:** 75% = $276.75
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.) **Fee:** $369.00 **Benefit:** 75% = $276.75
	PAIN RELIEF
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) **Fee:** $233.15 **Benefit:** 75% = $174.90 85% = $198.20
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.) **Fee:** $435.45 **Benefit:** 75% = $326.60 85% = $370.15
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,512.75 **Benefit:** 75% = $1,134.60
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.) **Fee:** $73.90 **Benefit:** 75% = $55.45 85% = $62.85
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) **Fee:** $292.30 **Benefit:** 75% = $219.25 85% = $248.50
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
39124	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) **Fee:** $1,586.65 **Benefit:** 75% = $1,190.00
39125	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $292.50 **Benefit:** 75% = $219.40
39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $355.15 **Benefit:** 75% = $266.40
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of chronic intractable pain (Anaes.) **Fee:** $464.80 **Benefit:** 75% = $348.60
39128	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agent or agents, with or without programming the pump, for the management of chronic intractable pain (Anaes.) (Assist.) **Fee:** $647.65 **Benefit:** 75% = $485.75

39130	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) **Fee:** $661.60 **Benefit:** 75% = $496.20
39131	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or reprogramming of neurostimulator by a medical practitioner, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris - each day **Fee:** $125.40 **Benefit:** 75% = $94.05 85% = $106.60
39133	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of chronic intractable pain (Anaes.) **Fee:** $156.45 **Benefit:** 75% = $117.35
39134	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement and connection of extension wires to epidural or peripheral nerve electrodes, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $334.25 **Benefit:** 75% = $250.70
39135	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) **Fee:** $156.45 **Benefit:** 75% = $117.35 85% = $133.00
39136	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, removal of, performed in the operating theatre of a hospital (Anaes.) **Fee:** $156.45 **Benefit:** 75% = $117.35
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct displacement or unsatisfactory positioning, including intraoperative test stimulation, not being a service to which item 39130, 39138 or 39139 applies (Anaes.) **Fee:** $594.05 **Benefit:** 75% = $445.55
39138	PERIPHERAL NERVE LEAD, surgical placement of, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris, to a maximum of 4 leads (Anaes.) (Assist.) **Fee:** $661.60 **Benefit:** 75% = $496.20
39139	EPIDURAL LEAD, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.) **Fee:** $888.20 **Benefit:** 75% = $666.15
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) **Fee:** $287.40 **Benefit:** 75% = $215.55 85% = $244.30
	PERIPHERAL NERVES
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $346.75 **Benefit:** 75% = $260.10
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $457.40 **Benefit:** 75% = $343.05
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $664.20 **Benefit:** 75% = $498.15
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $701.05 **Benefit:** 75% = $525.80
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $391.10 **Benefit:** 75% = $293.35
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,011.00 **Benefit:** 75% = $758.25
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) **Fee:** $627.30 **Benefit:** 75% = $470.50

39321	NERVE, transposition of (Anaes.) (Assist.) **Fee:** $464.80 **Benefit:** 75% = $348.60
39323	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $271.65 **Benefit:** 75% = $203.75 85% = $230.95
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.) **Fee:** $271.65 **Benefit:** 75% = $203.75 85% = $230.95
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.) **Fee:** $464.90 **Benefit:** 75% = $348.70 85% = $395.20
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) **Fee:** $271.65 **Benefit:** 75% = $203.75
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) **Fee:** $271.65 **Benefit:** 75% = $203.75 85% = $230.95
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $391.10 **Benefit:** 75% = $293.35 85% = $332.45
	CRANIAL NERVES
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.) **Fee:** $1,247.20 **Benefit:** 75% = $935.40
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90
	CRANIO-CEREBRAL INJURIES
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.) **Fee:** $464.80 **Benefit:** 75% = $348.60
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.) **Fee:** $1,173.40 **Benefit:** 75% = $880.05
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.) **Fee:** $782.25 **Benefit:** 75% = $586.70
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.) **Fee:** $1,099.55 **Benefit:** 75% = $824.70
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes.) (Assist.) **Fee:** $1,173.40 **Benefit:** 75% = $880.05
	SKULL BASE SURGERY
39640	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $2,975.10 **Benefit:** 75% = $2,231.35
39642	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $3,127.80 **Benefit:** 75% = $2,345.85

39646	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $3,585.50 **Benefit:** 75% = $2,689.15
39650	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $2,593.65 **Benefit:** 75% = $1,945.25
39653	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $4,615.45 **Benefit:** 75% = $3,461.60
39654	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $3,356.70 **Benefit:** 75% = $2,517.55
39656	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $2,517.45 **Benefit:** 75% = $1,888.10
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $2,975.10 **Benefit:** 75% = $2,231.35
39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $2,975.10 **Benefit:** 75% = $2,231.35
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.) *(See para T8.72 of explanatory notes to this Category)* **Fee:** $2,975.10 **Benefit:** 75% = $2,231.35
	INTRA-CRANIAL NEOPLASMS
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.) **Fee:** $546.20 **Benefit:** 75% = $409.65
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.) **Fee:** $509.30 **Benefit:** 75% = $382.00
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.) **Fee:** $1,092.10 **Benefit:** 75% = $819.10
39709	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90
39712	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) **Fee:** $2,811.60 **Benefit:** 75% = $2,108.70
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.) **Fee:** $1,948.30 **Benefit:** 75% = $1,461.25
39718	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.) **Fee:** $856.05 **Benefit:** 75% = $642.05

39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.) **Fee:** $782.25 **Benefit:** 75% = $586.70
	CEREBROVASCULAR DISEASE
39800	ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.) **Fee:** $2,804.25 **Benefit:** 75% = $2,103.20
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.) **Fee:** $2,804.25 **Benefit:** 75% = $2,103.20
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.) **Fee:** $1,261.80 **Benefit:** 75% = $946.35
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) **Fee:** $1,793.20 **Benefit:** 75% = $1,344.90 85% = $1,719.50
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.) **Fee:** $1,793.20 **Benefit:** 75% = $1,344.90
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.) **Fee:** $2,129.30 **Benefit:** 75% = $1,597.00
	INFECTION
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.) **Fee:** $509.30 **Benefit:** 75% = $382.00
39903	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.) **Fee:** $782.25 **Benefit:** 75% = $586.70
	CEREBROSPINAL FLUID CIRCULATION DISORDERS
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.) **Fee:** $900.30 **Benefit:** 75% = $675.25
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.) **Fee:** $900.30 **Benefit:** 75% = $675.25
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.) **Fee:** $708.50 **Benefit:** 75% = $531.40
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.) **Fee:** $516.60 **Benefit:** 75% = $387.45
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.) **Fee:** $1,011.00 **Benefit:** 75% = $758.25
40015	SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.) **Fee:** $626.75 **Benefit:** 75% = $470.10
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) **Fee:** $156.45 **Benefit:** 75% = $117.35 85% = $133.00
	CONGENITAL DISORDERS
40100	MENINGOCELE, excision and closure of (Anaes.) (Assist.) **Fee:** $678.85 **Benefit:** 75% = $509.15
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.) **Fee:** $996.30 **Benefit:** 75% = $747.25

40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.) **Fee:** $1,011.00 **Benefit:** 75% = $758.25
40109	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.) **Fee:** $1,092.10 **Benefit:** 75% = $819.10
40112	TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.) **Fee:** $1,402.10 **Benefit:** 75% = $1,051.60
40115	CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.) **Fee:** $708.50 **Benefit:** 75% = $531.40
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90
	SPINAL DISORDERS
40300	INTERVERTEBRAL DISC OR DISCS, partial or total laminectomy for removal of (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90
40301	INTERVERTEBRAL DISC OR DISCS, microsurgical partial or total discectomy of (Anaes.) (Assist.) **Fee:** $940.15 **Benefit:** 75% = $705.15
40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, partial or total laminectomy for - 1 level (Anaes.) (Assist.) **Fee:** $1,070.00 **Benefit:** 75% = $802.50
40306	SPINAL STENOSIS, partial or total laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.) (Assist.) **Fee:** $1,409.50 **Benefit:** 75% = $1,057.15
40309	EEXTRADURAL TUMOUR OR ABSCESS, partial or total laminectomy for (Anaes.) (Assist.) **Fee:** $1,070.00 **Benefit:** 75% = $802.50
40312	INTRADURAL LESION, partial or total laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,438.95 **Benefit:** 75% = $1,079.25
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90
40316	ODONTOID screw fixation (Anaes.) (Assist.) **Fee:** $2,040.95 **Benefit:** 75% = $1,530.75
40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, partial or total laminectomy and radical excision of (Anaes.) (Assist.) **Fee:** $1,948.30 **Benefit:** 75% = $1,461.25
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.) **Fee:** $1,070.00 **Benefit:** 75% = $802.50
40324	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – laminectomy, including aftercare (Anaes.) (Assist.) **Fee:** $627.30 **Benefit:** 75% = $470.50
40327	PARTIAL OR TOTAL LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together – posterior fusion, including aftercare (Assist.) **Fee:** $627.30 **Benefit:** 75% = $470.50
40330	SPINAL RHIZOLYSIS involving exposure of spinal nerve roots – for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at 1 or more levels – with or without partial or total laminectomy (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90
40331	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90

40332	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $1,529.25 **Benefit:** 75% = $1,146.95
40333	CERVICAL PARTIAL OR TOTAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.) **Fee:** $782.25 **Benefit:** 75% = $586.70
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:** $1,034.25 **Benefit:** 75% = $775.70
40335	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) **Fee:** $1,899.50 **Benefit:** 75% = $1,424.65
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (Anaes.) (Assist.) *(See para T8.73 of explanatory notes to this Category)* **Fee:** $310.00 **Benefit:** 75% = $232.50
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes.) (Assist.) **Fee:** $1,557.15 **Benefit:** 75% = $1,167.90
40342	HYDROMYELIA, craniotomy and partial or total laminectomy for, with cavity packing and CSF shunt (Anaes.) (Assist.) **Fee:** $1,438.95 **Benefit:** 75% = $1,079.25
40345	THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.) (Assist.) **Fee:** $1,339.55 **Benefit:** 75% = $1,004.70
40348	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.) **Fee:** $1,700.80 **Benefit:** 75% = $1,275.60
40351	THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.) (Assist.) **Fee:** $1,700.80 **Benefit:** 75% = $1,275.60
	SKULL RECONSTRUCTION
40600	CRANIOPLASTY, reconstructive (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90
	EPILEPSY
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.) **Fee:** $1,712.10 **Benefit:** 75% = $1,284.10
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.) **Fee:** $1,438.95 **Benefit:** 75% = $1,079.25
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.) **Fee:** $2,103.15 **Benefit:** 75% = $1,577.40 85% = $2,029.45
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.) **Fee:** $509.30 **Benefit:** 75% = $382.00
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.) **Fee:** $1,025.70 **Benefit:** 75% = $769.30
	STEREOTACTIC PROCEDURES
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.) **Fee:** $626.75 **Benefit:** 75% = $470.10 85% = $553.05

40801	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (Anaes.) (Assist.) **Fee:** $1,713.25 **Benefit:** 75% = $1,284.95
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.) **Fee:** $1,173.40 **Benefit:** 75% = $880.05 85% = $1,099.70
40850	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.) **Fee:** $2,222.25 **Benefit:** 75% = $1,666.70
40851	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.) **Fee:** $3,889.10 **Benefit:** 75% = $2,916.85
40852	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.) **Fee:** $334.25 **Benefit:** 75% = $250.70
40854	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $516.60 **Benefit:** 75% = $387.45
40856	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator receiver or pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $250.70 **Benefit:** 75% = $188.05
40858	DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extension lead for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $516.60 **Benefit:** 75% = $387.45
40860	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $1,985.00 **Benefit:** 75% = $1,488.75

40862	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neurostimulator pulse generator for the treatment of: Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) **Fee:** $186.15 **Benefit:** 75% = $139.65 85% = $158.25
	MISCELLANEOUS
40903	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.) **Fee:** $544.20 **Benefit:** 75% = $408.15
40905	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.) **Fee:** $590.50 **Benefit:** 75% = $442.90 85% = $516.80
	SUBGROUP 8 - EAR, NOSE AND THROAT
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) *(See para T8.74 of explanatory notes to this Category)* **Fee:** $80.95 **Benefit:** 75% = $60.75 85% = $68.85
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.) **Fee:** $234.35 **Benefit:** 75% = $175.80 85% = $199.20
41506	AURAL POLYP, removal of (Anaes.) **Fee:** $141.30 **Benefit:** 75% = $106.00 85% = $120.15
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) **Fee:** $159.90 **Benefit:** 75% = $119.95 85% = $135.95
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) **Fee:** $575.00 **Benefit:** 75% = $431.25
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $377.40 **Benefit:** 75% = $283.05
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) **Fee:** $911.45 **Benefit:** 75% = $683.60
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.) **Fee:** $970.40 **Benefit:** 75% = $727.80
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (Anaes.) (Assist.) *(See para T8.76 of explanatory notes to this Category)* **Fee:** $280.35 **Benefit:** 75% = $210.30
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) **Fee:** $939.45 **Benefit:** 75% = $704.60
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,122.95 **Benefit:** 75% = $842.25
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,257.80 **Benefit:** 75% = $943.35
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,069.60 **Benefit:** 75% = $802.20

41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) **Fee:** $1,172.00 **Benefit:** 75% = $879.00
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) **Fee:** $678.85 **Benefit:** 75% = $509.15
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) **Fee:** $1,563.35 **Benefit:** 75% = $1,172.55
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,841.95 **Benefit:** 75% = $1,381.50
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) **Fee:** $1,069.60 **Benefit:** 75% = $802.20
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) **Fee:** $1,172.00 **Benefit:** 75% = $879.00
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) **Fee:** $1,450.85 **Benefit:** 75% = $1,088.15
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.) **Fee:** $1,876.15 **Benefit:** 75% = $1,407.15
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) **Fee:** $1,069.60 **Benefit:** 75% = $802.20
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) **Fee:** $1,172.00 **Benefit:** 75% = $879.00
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) **Fee:** $1,013.95 **Benefit:** 75% = $760.50
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.) **Fee:** $2,390.30 **Benefit:** 75% = $1,792.75
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.) **Fee:** $3,585.50 **Benefit:** 75% = $2,689.15
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) **Fee:** $2,390.30 **Benefit:** 75% = $1,792.75
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) **Fee:** $1,792.70 **Benefit:** 75% = $1,344.55
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) **Fee:** $2,749.30 **Benefit:** 75% = $2,062.00
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) **Fee:** $1,886.80 **Benefit:** 75% = $1,415.10
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) **Fee:** $2,569.75 **Benefit:** 75% = $1,927.35
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) **Fee:** $1,172.00 **Benefit:** 75% = $879.00

41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) **Fee:** $1,527.50 **Benefit:** 75% = $1,145.65
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) **Fee:** $1,707.05 **Benefit:** 75% = $1,280.30
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) **Fee:** $1,707.05 **Benefit:** 75% = $1,280.30
41603	OSSEO-INTEGRATION PROCEDURE – implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $494.45 **Benefit:** 75% = $370.85 85% = $420.75
41604	OSSEO-INTEGRATION PROCEDURE – fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients: - With a permanent or long term hearing loss; and - Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and - With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted. Not being a service associated with a service to which items 41554, 45794 or 45797 (Anaes.) **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
41608	STAPEDECTOMY (Anaes.) (Assist.) **Fee:** $1,069.60 **Benefit:** 75% = $802.20
41611	STAPES MOBILISATION (Anaes.) (Assist.) **Fee:** $688.20 **Benefit:** 75% = $516.15
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) **Fee:** $1,069.60 **Benefit:** 75% = $802.20 85% = $995.90
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.) **Fee:** $1,069.60 **Benefit:** 75% = $802.20 85% = $995.90
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,859.85 **Benefit:** 75% = $1,394.90
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) **Fee:** $809.20 **Benefit:** 75% = $606.90
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) **Fee:** $1,172.00 **Benefit:** 75% = $879.00
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) **Fee:** $141.30 **Benefit:** 75% = $106.00 85% = $120.15
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) **Fee:** $234.35 **Benefit:** 75% = $175.80 85% = $199.20
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) **Fee:** $1,122.95 **Benefit:** 75% = $842.25 85% = $1,049.25
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) **Fee:** $1,401.70 **Benefit:** 75% = $1,051.30

41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) **Fee:** $46.55 **Benefit:** 75% = $34.95 85% = $39.60
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) **Fee:** $140.15 **Benefit:** 75% = $105.15 85% = $119.15
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) **Fee:** $107.85 **Benefit:** 75% = $80.90 85% = $91.70
41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $107.85 **Benefit:** 75% = $80.90 85% = $91.70
41653	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $70.60 **Benefit:** 75% = $52.95 85% = $60.05
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) **Fee:** $120.55 **Benefit:** 75% = $90.45 85% = $102.50
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) **Fee:** $76.10 **Benefit:** 75% = $57.10 85% = $64.70
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of *(See para T8.77 of explanatory notes to this Category)* **Fee:** $80.95 **Benefit:** 75% = $60.75 85% = $68.85
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.) *(See para T8.77 of explanatory notes to this Category)* **Fee:** $169.30 **Benefit:** 75% = $127.00 **Fee:** $215.85 **Benefit:** 75% = $161.90
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) **Fee:** $474.25 **Benefit:** 75% = $355.70
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) **Fee:** $591.60 **Benefit:** 75% = $443.70
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) **Fee:** $98.65 **Benefit:** 75% = $74.00 85% = $83.90
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) **Fee:** $88.30 **Benefit:** 75% = $66.25 85% = $75.10
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) **Fee:** $159.90 **Benefit:** 75% = $119.95 85% = $135.95
41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.) **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $70.60 **Benefit:** 75% = $52.95 85% = $60.05
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) **Fee:** $133.95 **Benefit:** 75% = $100.50
41692	TURBINATES, submucous resection of, unilateral (Anaes.) **Fee:** $174.75 **Benefit:** 75% = $131.10
41695	TURBINATES, cryotherapy to (Anaes.) **Fee:** $98.15 **Benefit:** 75% = $73.65 85% = $83.45

41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) **Fee:** $31.95 **Benefit:** 75% = $24.00 85% = $27.20
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $90.20 **Benefit:** 75% = $67.65
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) **Fee:** $35.60 **Benefit:** 75% = $26.70 85% = $30.30
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) **Fee:** $440.20 **Benefit:** 75% = $330.15
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) **Fee:** $595.20 **Benefit:** 75% = $446.40
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65
41719	ANTRUM, drainage of, through tooth socket (Anaes.) **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $502.95
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) **Fee:** $440.20 **Benefit:** 75% = $330.15
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) **Fee:** $880.55 **Benefit:** 75% = $660.45
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) **Fee:** $558.05 **Benefit:** 75% = $418.55
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) **Fee:** $762.60 **Benefit:** 75% = $571.95
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) **Fee:** $995.15 **Benefit:** 75% = $746.40
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) **Fee:** $474.25 **Benefit:** 75% = $355.70
41740	FRONTAL SINUS, catheterisation of (Anaes.) **Fee:** $57.70 **Benefit:** 75% = $43.30
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) **Fee:** $331.15 **Benefit:** 75% = $248.40
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) **Fee:** $762.60 **Benefit:** 75% = $571.95 85% = $688.90
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) **Fee:** $595.20 **Benefit:** 75% = $446.40
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) **Fee:** $45.65 **Benefit:** 75% = $34.25 85% = $38.85
41758	DIVISION OF PHARYNGEAL ADHESIONS (Anaes.) **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05

41761	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.) **Fee:** $120.55 **Benefit:** 75% = $90.45 85% = $102.50
41764	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures, unilateral or bilateral examination (Anaes.) **Fee:** $120.55 **Benefit:** 75% = $90.45 85% = $102.50
41767	NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.) **Fee:** $723.25 **Benefit:** 75% = $542.45 85% = $649.55
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) **Fee:** $688.20 **Benefit:** 75% = $516.15
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) **Fee:** $575.00 **Benefit:** 75% = $431.25
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) **Fee:** $688.20 **Benefit:** 75% = $516.15
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) **Fee:** $934.35 **Benefit:** 75% = $700.80 85% = $860.65
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) **Fee:** $1,159.15 **Benefit:** 75% = $869.40
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) **Fee:** $723.25 **Benefit:** 75% = $542.45
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.) **Fee:** $558.05 **Benefit:** 75% = $418.55 85% = $484.35
41788 G 41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.) **Fee:** $215.85 **Benefit:** 75% = $161.90 **Fee:** $290.20 **Benefit:** 75% = $217.65
41792 G 41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.) **Fee:** $271.65 **Benefit:** 75% = $203.75 **Fee:** $364.55 **Benefit:** 75% = $273.45
41796 G 41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) **Fee:** $111.60 **Benefit:** 75% = $83.70 **Fee:** $141.30 **Benefit:** 75% = $106.00
41800 G 41801 S	ADENOIDS, removal of (Anaes.) **Fee:** $115.35 **Benefit:** 75% = $86.55 **Fee:** $159.90 **Benefit:** 75% = $119.95
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) **Fee:** $88.30 **Benefit:** 75% = $66.25
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) **Fee:** $68.80 **Benefit:** 75% = $51.60 85% = $58.50
41810	UVULOTOMY or UVULECTOMY (Anaes.) **Fee:** $34.95 **Benefit:** 75% = $26.25 85% = $29.75
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) **Fee:** $182.15 **Benefit:** 75% = $136.65 85% = $154.85

41819	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes.) **Fee:** $342.45 **Benefit:** 75% = $256.85 85% = $291.10
41820	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, where the use of imaging intensification is clinically indicated (Anaes.) **Fee:** $410.95 **Benefit:** 75% = $308.25 85% = $349.35
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) **Fee:** $234.35 **Benefit:** 75% = $175.80
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) **Fee:** $51.25 **Benefit:** 75% = $38.45 85% = $43.60
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes.) (Assist.) **Fee:** $350.35 **Benefit:** 75% = $262.80 85% = $297.80
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) **Fee:** $224.25 **Benefit:** 75% = $168.20 85% = $190.65
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) **Fee:** $1,265.10 **Benefit:** 75% = $948.85
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,213.00 **Benefit:** 75% = $909.75
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) **Fee:** $1,491.45 **Benefit:** 75% = $1,118.60
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) **Fee:** $1,311.55 **Benefit:** 75% = $983.70
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.) *(See para T8.78 of explanatory notes to this Category)* **Fee:** $182.15 **Benefit:** 75% = $136.65 85% = $154.85
41849	LARYNX, direct examination of, with biopsy (Anaes.) (Assist.) **Fee:** $267.80 **Benefit:** 75% = $200.85
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) **Fee:** $282.85 **Benefit:** 75% = $212.15
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) *(See para T8.79 of explanatory notes to this Category)* **Fee:** $484.95 **Benefit:** 75% = $363.75
41861	MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.) **Fee:** $593.05 **Benefit:** 75% = $444.80
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) **Fee:** $399.90 **Benefit:** 75% = $299.95
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) **Fee:** $601.95 **Benefit:** 75% = $451.50
41868	LARYNGEAL WEB, division of, using microlarygoscopic techniques (Anaes.) **Fee:** $381.45 **Benefit:** 75% = $286.10

41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) **Fee:** $446.35 **Benefit:** 75% = $334.80
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $502.95
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $502.95
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) **Fee:** $934.35 **Benefit:** 75% = $700.80
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) **Fee:** $249.40 **Benefit:** 75% = $187.05
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.) **Fee:** $394.25 **Benefit:** 75% = $295.70
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) **Fee:** $89.35 **Benefit:** 75% = $67.05
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $282.55 **Benefit:** 75% = $211.95 85% = $240.20
41886	TRACHEA, removal of foreign body in (Anaes.) **Fee:** $174.75 **Benefit:** 75% = $131.10 85% = $148.55
41889	BRONCHOSCOPY, as an independent procedure (Anaes.) **Fee:** $174.75 **Benefit:** 75% = $131.10 85% = $148.55
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
41895	BRONCHUS, removal of foreign body in (Anaes.) (Assist.) **Fee:** $360.90 **Benefit:** 75% = $270.70
41898	FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) **Fee:** $252.15 **Benefit:** 75% = $189.15 85% = $214.35
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) **Fee:** $593.05 **Benefit:** 75% = $444.80
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) **Fee:** $241.90 **Benefit:** 75% = $181.45 85% = $205.65
41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) **Fee:** $444.90 **Benefit:** 75% = $333.70
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) **Fee:** $120.55 **Benefit:** 75% = $90.45 85% = $102.50
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) **Fee:** $382.95 **Benefit:** 75% = $287.25
	SUBGROUP 9 - OPHTHALMOLOGY
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $100.60 **Benefit:** 75% = $75.45
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) **Fee:** $472.30 **Benefit:** 75% = $354.25 85% = $401.50

42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) **Fee:** $597.70 **Benefit:** 75% = $448.30
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) **Fee:** $688.95 **Benefit:** 75% = $516.75
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) **Fee:** $472.30 **Benefit:** 75% = $354.25 85% = $401.50
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) **Fee:** $597.70 **Benefit:** 75% = $448.30
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.) **Fee:** $346.75 **Benefit:** 75% = $260.10
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) **Fee:** $1,180.75 **Benefit:** 75% = $885.60
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) **Fee:** $200.80 **Benefit:** 75% = $150.60 85% = $170.70
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) **Fee:** $819.05 **Benefit:** 75% = $614.30
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $494.45 **Benefit:** 75% = $370.85
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) **Fee:** $867.35 **Benefit:** 75% = $650.55
42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes.) (Assist.) **Fee:** $1,254.50 **Benefit:** 75% = $940.90
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) **Fee:** $745.25 **Benefit:** 75% = $558.95
42551	EYEBALL, PERFORATING WOUND OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
42554	EYEBALL, PERFORATING WOUND OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) **Fee:** $723.25 **Benefit:** 75% = $542.45
42557	EYEBALL, PERFORATING WOUND OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) **Fee:** $1,011.00 **Benefit:** 75% = $758.25
42560	INTRAOCULAR FOREIGN BODY, magnetic removal from anterior segment (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75

42563	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from anterior segment (Anaes.) (Assist.) **Fee:** $509.30 **Benefit:** 75% = $382.00 85% = $435.60
42566	INTRAOCULAR FOREIGN BODY, magnetic removal from posterior segment (Anaes.) (Assist.) **Fee:** $723.25 **Benefit:** 75% = $542.45
42569	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from posterior segment (Anaes.) (Assist.) **Fee:** $1,011.00 **Benefit:** 75% = $758.25
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) **Fee:** $115.15 **Benefit:** 75% = $86.40 85% = $97.90
42573	DERMOID, periorbital, excision of (Anaes.) **Fee:** $223.20 **Benefit:** 75% = $167.40 85% = $189.75
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) **Fee:** $474.25 **Benefit:** 75% = $355.70 85% = $403.15
42575	TARSAL CYST, extirpation of (Anaes.) **Fee:** $81.20 **Benefit:** 75% = $60.90 85% = $69.05
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) **Fee:** $115.15 **Benefit:** 75% = $86.40 85% = $97.90
42584	TARSORRHAPHY (Anaes.) (Assist.) **Fee:** $271.65 **Benefit:** 75% = $203.75 85% = $230.95
42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) **Fee:** $51.00 **Benefit:** 75% = $38.25 85% = $43.35
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) **Fee:** $332.05 **Benefit:** 75% = $249.05 85% = $282.25
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) **Fee:** $200.80 **Benefit:** 75% = $150.60
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) **Fee:** $494.45 **Benefit:** 75% = $370.85 85% = $420.75
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) **Fee:** $457.40 **Benefit:** 75% = $343.05 85% = $388.80
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $94.45 **Benefit:** 75% = $70.85 85% = $80.30
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) **Fee:** $141.65 **Benefit:** 75% = $106.25 85% = $120.45
42614	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare) **Fee:** $47.40 **Benefit:** 75% = $35.55 85% = $40.30

42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare) **Fee:** $70.90 **Benefit:** 75% = $53.20 85% = $60.30
42617	PUNCTUM SNIP operation (Anaes.) **Fee:** $134.40 **Benefit:** 75% = $100.80 85% = $114.25
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
42621	PUNCTUM, temporary occlusion of, by use of electrical cautery (Anaes.) **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) **Fee:** $81.20 **Benefit:** 75% = $60.90 85% = $69.05
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) **Fee:** $686.40 **Benefit:** 75% = $514.80
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) **Fee:** $1,107.00 **Benefit:** 75% = $830.25 85% = $1,033.30
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) **Fee:** $833.85 **Benefit:** 75% = $625.40
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) **Fee:** $115.15 **Benefit:** 75% = $86.40 85% = $97.90
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) **Fee:** $479.65 **Benefit:** 75% = $359.75 85% = $407.75
42644	CORNEA OR SCLERA, removal of imbedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) (Anaes.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $70.80 **Benefit:** 75% = $53.10 85% = $60.20
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) **Fee:** $200.80 **Benefit:** 75% = $150.60 85% = $170.70
42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) **Fee:** $70.80 **Benefit:** 75% = $53.10 85% = $60.20
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) **Fee:** $157.80 **Benefit:** 75% = $118.35 85% = $134.15
42653	CORNEA, transplantation of, full thickness (Anaes.) (Assist.) **Fee:** $1,313.50 **Benefit:** 75% = $985.15
42656	CORNEA, transplantation of, second and subsequent procedures (Anaes.) (Assist.) **Fee:** $1,638.30 **Benefit:** 75% = $1,228.75
42659	CORNEA, transplantation of, superficial or lamellar (Anaes.) (Assist.) **Fee:** $885.50 **Benefit:** 75% = $664.15 85% = $811.80
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) **Fee:** $885.50 **Benefit:** 75% = $664.15
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) **Fee:** $590.45 **Benefit:** 75% = $442.85 85% = $516.75

42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation **Fee:** $139.30 **Benefit:** 75% = $104.50 85% = $118.45
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) **Fee:** $73.90 **Benefit:** 75% = $55.45 85% = $62.85
42672	CORNEAL INCISONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres following anterior segment surgery, including appropriate measurements and calculations, performed as an independent procedure (Anaes.) (Assist.) *(See para T8.81 of explanatory notes to this Category)* **Fee:** $885.50 **Benefit:** 75% = $664.15 85% = $811.80
42673	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/_{2}$ dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.) **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $376.30
42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $113.55 **Benefit:** 75% = $85.20 85% = $96.55
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) **Fee:** $59.80 **Benefit:** 75% = $44.85 85% = $50.85
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO^2 or N^20 (Anaes.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) **Fee:** $118.10 **Benefit:** 75% = $88.60
42686	PTERYGIUM, removal of (Anaes.) **Fee:** $268.55 **Benefit:** 75% = $201.45 85% = $228.30
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) **Fee:** $115.15 **Benefit:** 75% = $86.40 85% = $97.90
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) **Fee:** $271.65 **Benefit:** 75% = $203.75 85% = $230.95
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $376.30
42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) **Fee:** $583.65 **Benefit:** 75% = $437.75 85% = $509.95
42701	ARTIFICIAL LENS, insertion of, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) **Fee:** $325.50 **Benefit:** 75% = $244.15 85% = $276.70
42702	LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS, excluding surgery performed for the correction of refractive error ***except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye*** (Anaes.) **Fee:** $746.45 **Benefit:** 75% = $559.85 85% = $672.75 **Extended Medicare Safety Net Cap:** $108.45
42703	ARTIFICIAL LENS, insertion of, into the posterior chamber and suture to the iris and sclera (Anaes.) (Assist.) **Fee:** $561.40 **Benefit:** 75% = $421.05 85% = $487.70
42704	ARTIFICIAL LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) **Fee:** $457.40 **Benefit:** 75% = $343.05 85% = $388.80
42707	ARTIFICIAL LENS, REMOVAL of and REPLACEMENT with a different lens, excluding surgery performed for the correction of refractive error except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye (Anaes.) **Fee:** $782.25 **Benefit:** 75% = $586.70 85% = $708.55

42710	ARTIFICIAL LENS, removal of, and replacement with a lens inserted into the posterior chamber and sutured to the iris or sclera (Anaes.) (Assist.) **Fee:** $885.50 **Benefit:** 75% = $664.15 85% = $811.80
42713	INTRAOCULAR LENSES, repositioning of, by the use of a McCannell suture or similar (Anaes.) (Assist.) **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) **Fee:** $1,173.40 **Benefit:** 75% = $880.05 85% = $1,099.70
42719	CAPSULECTOMY OR REMOVAL OF VITREOUS, or both, via the anterior chamber by any method, not being a service associated with a service to which item 42698, 42702 or 42716 applies (Anaes.) (Assist.) **Fee:** $509.30 **Benefit:** 75% = $382.00 85% = $435.60
42722	CAPSULECTOMY by posterior chamber sclerotomy OR REMOVAL OF VITREOUS or VITREOUS BANDS, or both, from the anterior chamber by posterior chamber sclerotomy, by cutting and suction and infusion, not being a service associated with a service to which item 42698, 42702 or 42716 applies - 1 or both procedures (Anaes.) (Assist.) **Fee:** $557.05 **Benefit:** 75% = $417.80
42725	VITRECTOMY by posterior chamber sclerotomy including the removal of vitreous, division of bands or removal of preretinal membranes where performed, by cutting and suction and infusion (Anaes.) (Assist.) **Fee:** $1,313.50 **Benefit:** 75% = $985.15
42728	CRYOTHERAPY OF RETINA or other intraocular structures with an internal probe, being a service associated with a service to which item 42725 applies (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15
42731	CAPSULECTOMY or LENSECTOMY, or both, by posterior chamber sclerotomy in conjunction with the removal of vitreous or division of vitreous bands or removal of preretinal membrane from the posterior chamber by cutting and suction and infusion, not being a service associated with any other intraocular operation (Anaes.) (Assist.) *(See para T8.82 of explanatory notes to this Category)* **Fee:** $1,490.70 **Benefit:** 75% = $1,118.05
42734	CAPSULOTOMY, other than by laser (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
42737	NEEDLING OF POSTERIOR CAPSULE (Anaes.) (Assist.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
New 42738	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure. (See para T8.125 of explanatory notes to this Category) Fee: $295.15 Benefit: 75% = $221.40 85% = $250.90
New 42739	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure, for a patient requiring anaesthetic services. (Anaes.) (See para T8.125 of explanatory notes to this Category) Fee: $295.15 Benefit: 75% = $221.40 85% = $250.90

Amend 42740	INTRAVITREAL INJECTION OF THERAPEUTIC SUBSTANCES, or the removal of vitreous humour for diagnostic purposes, 1 or more of, as a procedure associated with other intraocular surgery. (Anaes.) *(See para T8.125 of explanatory notes to this Category)* **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
42741	Posterior juxtascleral depot injection of a therapeutic substance, for the treatment of subfoveal choroidal neovascularisation due to age-related macular degeneration, 1 or more of (Anaes.) *(See para T8.83 of explanatory notes to this Category)* **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
42744	NEEDLING FOR DRAINAGE OF ENCYSTED BLEB, following trabeculectomy (Anaes.) **Fee:** $294.95 **Benefit:** 75% = $221.25 85% = $250.75
42746	GLAUCOMA, filtering operation for (Anaes.) (Assist.) **Fee:** $937.20 **Benefit:** 75% = $702.90
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) **Fee:** $1,173.40 **Benefit:** 75% = $880.05
42752	GLAUCOMA, insertion of Molteno valve for, 1 or more stages (Anaes.) (Assist.) **Fee:** $1,313.50 **Benefit:** 75% = $985.15
42755	GLAUCOMA, removal of Molteno valve (Anaes.) **Fee:** $162.35 **Benefit:** 75% = $121.80 85% = $138.00

42758	GONIOTOMY (Anaes.) (Assist.) **Fee:** $686.40 **Benefit:** 75% = $514.80
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $509.30 **Benefit:** 75% = $382.00 85% = $435.60
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) **Fee:** $509.30 **Benefit:** 75% = $382.00 85% = $435.60
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) **Fee:** $1,070.00 **Benefit:** 75% = $802.50
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $289.30 **Benefit:** 75% = $217.00 85% = $245.95
42771	CYCLODESTRUCTIVE PROCEDURES for the treatment of intractable glaucoma, treatment to one eye - ***where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which 42770 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.84 of explanatory notes to this Category)* **Fee:** $284.90 **Benefit:** 75% = $213.70 85% = $242.20
42773	DETACHED RETINA, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) **Fee:** $885.50 **Benefit:** 75% = $664.15 85% = $811.80
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) **Fee:** $1,313.50 **Benefit:** 75% = $985.15
42779	DETACHED RETINA, revision operation for (Anaes.) (Assist.) **Fee:** $1,638.30 **Benefit:** 75% = $1,228.75
42782	LASER TRABECULOPLASTY - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $376.30
42783	LASER TRABECULOPLASTY - each treatment to 1 eye - ***where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $376.30
42785	LASER IRIDOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.86 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
42786	LASER IRIDOTOMY - each treatment episode to 1 eye - ***where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.86 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
42788	LASER CAPSULOTOMY - each treatment episode to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.87 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
42789	LASER CAPSULOTOMY - each treatment episode to 1 eye - ***where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.87 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75

42791	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS -each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) *(See para T8.88 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
42792	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - each treatment to 1 eye ***- where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period*** (Anaes.) (Assist.) *(See para T8.88 of explanatory notes to this Category)* **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
42794	DIVISION OF SUTURE BY LASER following trabeculoplasty, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) *(See para T8.89 of explanatory notes to this Category)* **Fee:** $66.40 **Benefit:** 75% = $49.80 85% = $56.45
42797	LASER COAGULATION OF CORNEAL OR SCLERAL BLOOD VESSELS - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) *(See para T8.90 of explanatory notes to this Category)* **Fee:** $66.40 **Benefit:** 75% = $49.80 85% = $56.45
42801	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, insertion of (Anaes.) (Assist.) **Fee:** $1,030.15 **Benefit:** 75% = $772.65
42802	EPISCLERAL RADIOACTIVE PLAQUE (Ruthenium 106 or Iodine 125), for the treatment of choroidal melanomas, removal of (Anaes.) (Assist.) **Fee:** $514.90 **Benefit:** 75% = $386.20
42805	TANTALUM MARKERS, surgical insertion to the sclera to localise the tumour base to assist in planning of radiotherapy of choroidal melanomas, 1 or more (Anaes.) (Assist.) **Fee:** $575.55 **Benefit:** 75% = $431.70 85% = $501.85
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) **Fee:** $346.75 **Benefit:** 75% = $260.10 85% = $294.75
42807	PHOTOMYDRIASIS, laser **Fee:** $349.15 **Benefit:** 75% = $261.90 85% = $296.80
42808	PHOTOIRIDOSYNERESIS, laser **Fee:** $349.15 **Benefit:** 75% = $261.90 85% = $296.80
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $376.30
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) **Fee:** $557.10 **Benefit:** 75% = $417.85 85% = $483.40
42811	TRANSPUPILLARY THERMOTHERAPY, for treatment of choroidal and retinal tumours or vascular malformations (Anaes.) **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $376.30
42812	DETACHED RETINA, removal of encircling silicone band from (Anaes.) **Fee:** $162.35 **Benefit:** 75% = $121.80 85% = $138.00
42815	POSTERIOR CHAMBER, removal of silicone oil from (Anaes.) (Assist.) **Fee:** $619.95 **Benefit:** 75% = $465.00
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, with external probe (Anaes.) **Fee:** $575.55 **Benefit:** 75% = $431.70 85% = $501.85
42821	OCULAR TRANSILLUMINATION, for the diagnosis and measurement of intraocular tumours (Anaes.) **Fee:** $88.65 **Benefit:** 75% = $66.50 85% = $75.40
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $68.60 **Benefit:** 75% = $51.45 85% = $58.35

42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $575.55 **Benefit:** 75% = $431.70
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $715.85 **Benefit:** 75% = $536.90
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $686.40 **Benefit:** 75% = $514.80
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 or MORE MUSCLES, on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $856.05 **Benefit:** 75% = $642.05
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) *(See para T8.91 of explanatory notes to this Category)* **Fee:** $185.85 **Benefit:** 75% = $139.40 85% = $158.00
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 15 years or over (Anaes.) (Assist.) **Fee:** $686.40 **Benefit:** 75% = $514.80
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or under, or where the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, or on a patient with concurrent thyroid eye disease (Anaes.) (Assist.) **Fee:** $856.05 **Benefit:** 75% = $642.05
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) **Fee:** $885.50 **Benefit:** 75% = $664.15 85% = $811.80
42863	EYELID, recession of (Anaes.) (Assist.) **Fee:** $760.10 **Benefit:** 75% = $570.10 85% = $686.40
42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.) **Fee:** $737.85 **Benefit:** 75% = $553.40 85% = $664.15
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) **Fee:** $538.75 **Benefit:** 75% = $404.10 85% = $465.05
42872	EYEBROW, elevation of, for paretic states (Anaes.) **Fee:** $236.20 **Benefit:** 75% = $177.15 85% = $200.80
43021	Photodynamic therapy, one eye, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $446.55 **Benefit:** 75% = $334.95 85% = $379.60
43022	Photodynamic therapy, both eyes, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation. **Fee:** $535.95 **Benefit:** 75% = $402.00 85% = $462.25
43023	Infusion of Verteporfin for discontinued photodynamic therapy, where a session of therapy which would have been provided under item 43021 or 43022 has been discontinued on medical grounds. **Fee:** $86.85 **Benefit:** 75% = $65.15 85% = $73.85

	SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS
	ACUTE
43500	OPERATION ON PHALANX (Anaes.) **Fee:** $121.05 **Benefit:** 75% = $90.80
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) **Fee:** $200.90 **Benefit:** 75% = $150.70
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
	CHRONIC
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30 85% = $297.25
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50
43521	OPERATION ON SKULL (Anaes.) (Assist.) **Fee:** $455.85 **Benefit:** 75% = $341.90
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $502.95
	SUBGROUP 11 - PAEDIATRIC
	SURGERY IN NEONATE OR YOUNG CHILD
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) **Fee:** $939.45 **Benefit:** 75% = $704.60
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) **Fee:** $1,000.25 **Benefit:** 75% = $750.20
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.) (Assist.) **Fee:** $1,091.25 **Benefit:** 75% = $818.45
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) **Fee:** $1,273.15 **Benefit:** 75% = $954.90
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal perforation with or without meconium peritonitis (Anaes.) (Assist.) **Fee:** $1,273.15 **Benefit:** 75% = $954.90
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.) **Fee:** $1,182.15 **Benefit:** 75% = $886.65
43819	HIRSCHSPRUNG'S DISEASE, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) **Fee:** $954.80 **Benefit:** 75% = $716.10
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) **Fee:** $954.80 **Benefit:** 75% = $716.10

43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $1,091.25 **Benefit:** 75% = $818.45
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,205.65 **Benefit:** 75% = $904.25
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) **Fee:** $939.45 **Benefit:** 75% = $704.60
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) **Fee:** $1,091.25 **Benefit:** 75% = $818.45
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) **Fee:** $1,364.00 **Benefit:** 75% = $1,023.00
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.) **Fee:** $1,182.15 **Benefit:** 75% = $886.65
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.) **Fee:** $1,818.80 **Benefit:** 75% = $1,364.10
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.) **Fee:** $1,955.15 **Benefit:** 75% = $1,466.40
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) **Fee:** $500.15 **Benefit:** 75% = $375.15
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) **Fee:** $1,591.30 **Benefit:** 75% = $1,193.50 85% = $1,517.60
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) **Fee:** $1,682.40 **Benefit:** 75% = $1,261.80
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) **Fee:** $591.00 **Benefit:** 75% = $443.25 85% = $517.30
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) **Fee:** $1,636.95 **Benefit:** 75% = $1,227.75
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) **Fee:** $1,227.70 **Benefit:** 75% = $920.80
43867	GASTROSCHISIS, secondary operation for, with removal of silo and closure of abdominal wall (Anaes.) (Assist.) **Fee:** $682.05 **Benefit:** 75% = $511.55
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) **Fee:** $954.80 **Benefit:** 75% = $716.10
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) **Fee:** $1,273.15 **Benefit:** 75% = $954.90
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) **Fee:** $1,091.25 **Benefit:** 75% = $818.45
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) **Fee:** $1,273.15 **Benefit:** 75% = $954.90

43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) **Fee:** $1,636.95 **Benefit:** 75% = $1,227.75 85% = $1,563.25
	THORACIC SURGERY
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) **Fee:** $1,091.25 **Benefit:** 75% = $818.45
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) **Fee:** $1,818.80 **Benefit:** 75% = $1,364.10
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) **Fee:** $1,591.30 **Benefit:** 75% = $1,193.50
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) **Fee:** $1,591.30 **Benefit:** 75% = $1,193.50
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) **Fee:** $1,503.45 **Benefit:** 75% = $1,127.60
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) **Fee:** $1,136.70 **Benefit:** 75% = $852.55 85% = $1,063.00
	ABDOMINAL SURGERY
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) **Fee:** $437.10 **Benefit:** 75% = $327.85
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) **Fee:** $511.70 **Benefit:** 75% = $383.80
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) **Fee:** $954.80 **Benefit:** 75% = $716.10
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) **Fee:** $727.50 **Benefit:** 75% = $545.65
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) **Fee:** $227.40 **Benefit:** 75% = $170.55 85% = $193.30
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) **Fee:** $954.80 **Benefit:** 75% = $716.10
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) **Fee:** $136.50 **Benefit:** 75% = $102.40 85% = $116.05
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) **Fee:** $855.05 **Benefit:** 75% = $641.30
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,045.90 **Benefit:** 75% = $784.45
43957	GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or without hiatus hernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.) **Fee:** $1,136.70 **Benefit:** 75% = $852.55
43960	ANORECTAL MALFORMATION, perineal anoplasty of (Anaes.) (Assist.) **Fee:** $399.90 **Benefit:** 75% = $299.95
43963	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.) **Fee:** $1,591.30 **Benefit:** 75% = $1,193.50

43966	ANORECTAL MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.) (Assist.) **Fee:** $1,818.80 **Benefit:** 75% = $1,364.10
43969	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with or without laparotomy (Anaes.) (Assist.) **Fee:** $2,500.85 **Benefit:** 75% = $1,875.65
43972	CHOLEDOCHAL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.) **Fee:** $1,818.80 **Benefit:** 75% = $1,364.10
43975	CHOLEDOCHAL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.) **Fee:** $2,137.10 **Benefit:** 75% = $1,602.85
43978	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.) **Fee:** $1,818.80 **Benefit:** 75% = $1,364.10
43981	NEPHROBLASTOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) **Fee:** $500.15 **Benefit:** 75% = $375.15
43984	NEPHROBLASTOMA, radical nephrectomy for (Anaes.) (Assist.) **Fee:** $1,273.15 **Benefit:** 75% = $954.90
43987	NEUROBLASTOMA, radical excision of (Anaes.) (Assist.) **Fee:** $1,409.60 **Benefit:** 75% = $1,057.20
43990	HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends to sigmoid colon (Anaes.) (Assist.) **Fee:** $1,727.90 **Benefit:** 75% = $1,295.95
43993	HIRSCHSPRUNG'S DISEASE, definitive resection with pull-through anastomosis, with or without frozen section biopsies, when aganglionic segment extends into descending or transverse colon with or without resiting of stoma (Anaes.) (Assist.) **Fee:** $1,864.25 **Benefit:** 75% = $1,398.20 85% = $1,790.55
43996	HIRSCHPRUNG'S DISEASE, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or without side to side ileocolic anastomosis (Anaes.) (Assist.) **Fee:** $2,091.60 **Benefit:** 75% = $1,568.70 85% = $2,017.90
43999	HIRSCHSPRUNG'S DISEASE, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.) **Fee:** $261.60 **Benefit:** 75% = $196.20
44102	RECTUM, examination of, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.) **Fee:** $252.15 **Benefit:** 75% = $189.15
44105	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, under general anaesthesia (Anaes.) **Fee:** $44.25 **Benefit:** 75% = $33.20 85% = $37.65
44108	INGUINAL HERNIA repair at age less than 3 months (Anaes.) (Assist.) **Fee:** $482.30 **Benefit:** 75% = $361.75
44111	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair of, at age less than 3 months, including orchidopexy when performed (Anaes.) (Assist.) **Fee:** $564.90 **Benefit:** 75% = $423.70 85% = $491.20
44114	INGUINAL HERNIA repair at age less than 3 months when orchidopexy also required (Anaes.) (Assist.) **Fee:** $564.90 **Benefit:** 75% = $423.70
	MISCELLANEOUS SURGERY
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) **Fee:** $454.65 **Benefit:** 75% = $341.00 85% = $386.50
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) **Fee:** $360.90 **Benefit:** 75% = $270.70

44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
	SUBGROUP 12 - AMPUTATIONS
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65 85% = $246.70
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) **Fee:** $1,172.00 **Benefit:** 75% = $879.00 85% = $1,098.30
44338	1 DIGIT of foot, amputation of (Anaes.) **Fee:** $141.30 **Benefit:** 75% = $106.00 85% = $120.15
44342	2 DIGITS of 1 foot, amputation of (Anaes.) **Fee:** $215.85 **Benefit:** 75% = $161.90
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $249.25 **Benefit:** 75% = $186.95
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $282.85 **Benefit:** 75% = $212.15 85% = $240.45
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) **Fee:** $323.65 **Benefit:** 75% = $242.75
44358	TOE, including metatarsal or part of metatarsal each toe , amputation of (Anaes.) **Fee:** $180.45 **Benefit:** 75% = $135.35
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare (Anaes.) (Assist.) **Fee:** $259.05 **Benefit:** 75% = $194.30
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) **Fee:** $290.20 **Benefit:** 75% = $217.65
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) **Fee:** $512.20 **Benefit:** 75% = $384.15
44370	AMPUTATION AT HIP (Anaes.) (Assist.) **Fee:** $706.75 **Benefit:** 75% = $530.10
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) **Fee:** $1,450.85 **Benefit:** 75% = $1,088.15 85% = $1,377.15
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) **Derived Fee:** 75% of the original amputation fee

	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
	GENERAL
	METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR *(Note: See Explanatory notes to this Category for definition of "Local skin flap")*
45000	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.) **Fee:** $531.25 **Benefit:** 75% = $398.45 85% = $457.55
45003	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (Anaes.) **Fee:** $590.45 **Benefit:** 75% = $442.85 85% = $516.75
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.) **Fee:** $1,018.30 **Benefit:** 75% = $763.75
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.) **Fee:** $372.00 **Benefit:** 75% = $279.00
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.) **Fee:** $623.15 **Benefit:** 75% = $467.40
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.) **Fee:** $295.15 **Benefit:** 75% = $221.40
45018	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) **Fee:** $464.80 **Benefit:** 75% = $348.60 85% = $395.10
45019	FULL FACE CHEMICAL PEEL **for severely sun-damaged skin*, where it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin***, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.) *(See para T8.92 of explanatory notes to this Category)* **Fee:** $389.30 **Benefit:** 75% = $292.00
45020	FULL FACE CHEMICAL PEEL **for severe chloasma or melasma refractory to all other treatments**, ***where it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres***, *where at least medium depth peeling agents are used*, performed in the operating theatre of a hospital by a specialist in the practice of his or her specialty - ***1 session only in a 12 month period*** (Anaes.) *(See para T8.92 of explanatory notes to this Category)* **Fee:** $389.30 **Benefit:** 75% = $292.00 85% = $330.95
45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $174.05 **Benefit:** 75% = $130.55 85% = $147.95
45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $391.10 **Benefit:** 75% = $293.35 85% = $332.45
45025	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $174.05 **Benefit:** 75% = $130.55 85% = $147.95
45026	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) *(See para T8.93 of explanatory notes to this Category)* **Fee:** $391.10 **Benefit:** 75% = $293.35 85% = $332.45

45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $118.10 **Benefit:** 75% = $88.60 85% = $100.40
45030	ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.) **Fee:** $126.85 **Benefit:** 75% = $95.15 85% = $107.85
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) **Fee:** $236.20 **Benefit:** 75% = $177.15 85% = $200.80
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) **Fee:** $688.95 **Benefit:** 75% = $516.75
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) **Fee:** $1,107.00 **Benefit:** 75% = $830.25
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) **Fee:** $236.20 **Benefit:** 75% = $177.15 85% = $200.80
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) **Fee:** $302.65 **Benefit:** 75% = $227.00 85% = $257.30
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) **Fee:** $302.65 **Benefit:** 75% = $227.00 85% = $257.30
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) **Fee:** $760.10 **Benefit:** 75% = $570.10
45051	CONTOUR RECONSTRUCTION for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (Anaes.) (Assist.) *(See para T8.94 of explanatory notes to this Category)* **Fee:** $464.90 **Benefit:** 75% = $348.70
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) *(See para T8.95 of explanatory notes to this Category)* **Fee:** $241.50 **Benefit:** 75% = $181.15
	SKIN FLAP SURGERY
45200	*(Note: See Explanatory notes to this Category for definition of "Local skin flap")* SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $279.05 **Benefit:** 75% = $209.30 85% = $237.20
45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap (Anaes.) (Assist.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75
45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, and excluding H-flap or double advancement flap (Anaes.) *(See para T8.96 of explanatory notes to this Category)* **Fee:** $376.40 **Benefit:** 75% = $282.30 85% = $319.95
45207	H-FLAP OR DOUBLE ADVANCEMENT FLAP where indicated to repair 1 defect, on eyelid, eyebrow or forehead (Anaes.) **Fee:** $376.40 **Benefit:** 75% = $282.30 85% = $319.95
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.) **Fee:** $464.90 **Benefit:** 75% = $348.70 85% = $395.20
45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (Anaes.) **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10

45215	DIRECT FLAP REPAIR, cross leg, first stage (Anaes.) (Assist.) **Fee:** $995.15 **Benefit:** 75% = $746.40
45218	DIRECT FLAP REPAIR, cross leg, second stage (Anaes.) (Assist.) **Fee:** $446.35 **Benefit:** 75% = $334.80
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes.) **Fee:** $256.65 **Benefit:** 75% = $192.50 85% = $218.20
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (Anaes.) **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (Anaes.) (Assist.) **Fee:** $437.10 **Benefit:** 75% = $327.85 85% = $371.55
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.) **Fee:** $218.60 **Benefit:** 75% = $163.95 85% = $185.85
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.) **Fee:** $464.90 **Benefit:** 75% = $348.70 85% = $395.20
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.) **Fee:** $364.55 **Benefit:** 75% = $273.45
45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.) **Fee:** $256.65 **Benefit:** 75% = $192.50 85% = $218.20
45240	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.) **Fee:** $256.65 **Benefit:** 75% = $192.50 85% = $218.20
	FREE GRAFTS
45400	FREE GRAFTING (split skin) of a granulating area, small (Anaes.) **Fee:** $200.90 **Benefit:** 75% = $150.70 85% = $170.80
45403	FREE GRAFTING (split skin) of a granulating area, extensive (Anaes.) (Assist.) **Fee:** $399.90 **Benefit:** 75% = $299.95 85% = $339.95
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (Anaes.) (Assist.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $442.70 **Benefit:** 75% = $332.05 85% = $376.30
45409	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (Anaes.) (Assist.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $590.45 **Benefit:** 75% = $442.85
45412	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (Anaes.) (Assist.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $811.85 **Benefit:** 75% = $608.90
45415	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (Anaes.) (Assist.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $885.50 **Benefit:** 75% = $664.15
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more but less than 15 per cent of total body surface (Anaes.) (Assist.) *(See para T8.97 of explanatory notes to this Category)* **Fee:** $959.30 **Benefit:** 75% = $719.50
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (Anaes.) **Fee:** $279.05 **Benefit:** 75% = $209.30 85% = $237.20

45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) **Fee:** $575.55 **Benefit:** 75% = $431.70 85% = $501.85
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.) **Fee:** $546.20 **Benefit:** 75% = $409.65 85% = $472.50
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.) **Fee:** $369.00 **Benefit:** 75% = $276.75 85% = $313.65
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) **Fee:** $464.90 **Benefit:** 75% = $348.70 85% = $395.20
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.) **Fee:** $1,229.95 **Benefit:** 75% = $922.50
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $876.60 **Benefit:** 75% = $657.45
45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***15 percent or more but less than 20 percent*** of total body surface - **conjoint surgery, co- surgeon** (Assist.) **Fee:** $661.50 **Benefit:** 75% = $496.15
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **one surgeon** (Anaes.) (Assist.) **Fee:** $1,877.45 **Benefit:** 75% = $1,408.10
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $1,337.60 **Benefit:** 75% = $1,003.20 85% = $1,263.90
45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***20 percent or more but less than 30 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,008.80 **Benefit:** 75% = $756.60 85% = $935.10
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $1,798.50 **Benefit:** 75% = $1,348.90
45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***30 percent or more but less than 40 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,356.90 **Benefit:** 75% = $1,017.70 85% = $1,283.20
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $2,260.70 **Benefit:** 75% = $1,695.55 85% = $2,187.00
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***40 percent or more but less than 50 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $1,705.20 **Benefit:** 75% = $1,278.90 85% = $1,631.50
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $2,721.60 **Benefit:** 75% = $2,041.20 85% = $2,647.90
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***50 percent or more but less than 60 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,053.45 **Benefit:** 75% = $1,540.10 85% = $1,979.75
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $3,182.55 **Benefit:** 75% = $2,386.95 85% = $3,108.85

45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***60 percent or more but less than 70 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,400.45 **Benefit:** 75% = $1,800.35 85% = $2,326.75
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $3,643.40 **Benefit:** 75% = $2,732.55 85% = $3,569.70
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***70 percent or more but less than 80 percent*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $2,748.85 **Benefit:** 75% = $2,061.65 85% = $2,675.15
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, principal surgeon** (Anaes.) (Assist.) **Fee:** $4,151.10 **Benefit:** 75% = $3,113.35 85% = $4,077.40
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving ***80 percent or more*** of total body surface - **conjoint surgery, co-surgeon** (Assist.) **Fee:** $3,132.00 **Benefit:** 75% = $2,349.00 85% = $3,058.30
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.) **Fee:** $517.85 **Benefit:** 75% = $388.40
45486	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.) **Fee:** $442.70 **Benefit:** 75% = $332.05
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) **Fee:** $442.70 **Benefit:** 75% = $332.05
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) **Fee:** $664.20 **Benefit:** 75% = $498.15 85% = $590.50
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) **Fee:** $885.65 **Benefit:** 75% = $664.25
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) **Fee:** $1,107.00 **Benefit:** 75% = $830.25
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.) **Fee:** $1,328.35 **Benefit:** 75% = $996.30
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) **Fee:** $1,608.15 **Benefit:** 75% = $1,206.15 85% = $1,534.45
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
45496	FLAP, free tissue transfer using microvascular techniques - ***revision of***, by open operation (Anaes.) **Fee:** $408.30 **Benefit:** 75% = $306.25
45497	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***complete revision of***, by liposuction (Anaes.) **Fee:** $318.90 **Benefit:** 75% = $239.20
45498	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***staged revision of***, by liposuction - first stage (Anaes.) **Fee:** $256.65 **Benefit:** 75% = $192.50

45499	FLAP, free tissue transfer using microvascular techniques, *or* any autogenous breast reconstruction - ***staged revision of***, by liposuction - second stage (Anaes.) **Fee:** $191.35 **Benefit:** 75% = $143.55
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) **Fee:** $1,070.00 **Benefit:** 75% = $802.50
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,741.60 **Benefit:** 75% = $1,306.20
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) **Fee:** $1,741.60 **Benefit:** 75% = $1,306.20
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,992.50 **Benefit:** 75% = $1,494.40
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,741.60 **Benefit:** 75% = $1,306.20
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) **Fee:** $1,741.60 **Benefit:** 75% = $1,306.20
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $215.85 **Benefit:** 75% = $161.90 85% = $183.50
45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $290.20 **Benefit:** 75% = $217.65 85% = $246.70
45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or where performed by a specialist in the practice of his or her specialty (Anaes.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.) *(See para T8.98 of explanatory notes to this Category)* **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) **Fee:** $421.05 **Benefit:** 75% = $315.80
45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes.) (Assist.) **Fee:** $883.65 **Benefit:** 75% = $662.75
45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia (Anaes.) (Assist.) *(See para T8.99 of explanatory notes to this Category)* **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $727.80 **Benefit:** 75% = $545.85
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $727.80 **Benefit:** 75% = $545.85

45528	MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45527 applies, ***where it can be demonstrated*** that surgery is indicated because of malformation of breast tissue (excluding hypomastia), disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.) *(See para T8.100 of explanatory notes to this Category)* **Fee:** $1,091.60 **Benefit:** 75% = $818.70
45530	BREAST RECONSTRUCTION (unilateral) using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, not being a service associated with a service to which items 30165, 30168, 30171, 30174 or 30177 applies (Anaes.) (Assist.) *(See para T8.101 of explanatory notes to this Category)* **Fee:** $1,078.90 **Benefit:** 75% = $809.20
45533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.) **Fee:** $1,221.90 **Benefit:** 75% = $916.45
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.) **Fee:** $449.30 **Benefit:** 75% = $337.00
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,051.25 **Benefit:** 75% = $788.45
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.) **Fee:** $601.95 **Benefit:** 75% = $451.50
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) *(See para T8.104 of explanatory notes to this Category)* **Fee:** $610.95 **Benefit:** 75% = $458.25 85% = $537.25
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple *(See para T8.104 of explanatory notes to this Category)* **Fee:** $194.15 **Benefit:** 75% = $145.65 85% = $165.05
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.) **Fee:** $271.65 **Benefit:** 75% = $203.75 85% = $230.95
45551	BREAST PROSTHESIS, removal of, with excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $435.45 **Benefit:** 75% = $326.60
45552	BREAST PROSTHESIS, removal of, with excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $626.75 **Benefit:** 75% = $470.10 85% = $553.05
45553	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation). (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $626.75 **Benefit:** 75% = $470.10 85% = $553.05
45554	BREAST PROSTHESIS, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $686.40 **Benefit:** 75% = $514.80 85% = $612.70
45555	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.) (Assist.) *(See para T8.102 of explanatory notes to this Category)* **Fee:** $626.75 **Benefit:** 75% = $470.10
45556	BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (Anaes.) (Assist.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $751.75 **Benefit:** 75% = $563.85 85% = $678.05

45557	BREAST PTOSIS, correction of by mastopexy by any means (unilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove, not being a service associated with a service to which item 45522 applies (Anaes.) (Assist.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $751.75 **Benefit:** 75% = $563.85
45558	BREAST PTOSIS, correction of by mastopexy by any means (bilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and ***where it can be demonstrated*** that the nipple is inferior to the infra-mammary groove, not being a service associated with a service to which item 45522 applies (Anaes.) (Assist.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $1,127.55 **Benefit:** 75% = $845.70
45559	TUBEROUS, TUBULAR OR CONSTRICTED BREAST, **where it can be demonstrated,** correction of by simultaneous mastopexy and augmentation of (unilateral) (Anaes.) (Assist.) *(See para T8.103 of explanatory notes to this Category)* **Fee:** $1,115.60 **Benefit:** 75% = $836.70 85% = $1,041.90
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.) **Fee:** $464.80 **Benefit:** 75% = $348.60 85% = $395.10 **Extended Medicare Safety Net Cap:** $162.65
45561	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for supercharging of pedicled flaps (Anaes.) (Assist.) **Fee:** $1,741.60 **Benefit:** 75% = $1,306.20
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,078.90 **Benefit:** 75% = $809.20 85% = $1,005.20
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) **Fee:** $1,078.90 **Benefit:** 75% = $809.20 85% = $1,005.20
45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.) **Fee:** $2,498.80 **Benefit:** 75% = $1,874.10
45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of up to 2 of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, insetting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 30165, 30168, 30171, 30174, 30177, 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.) **Fee:** $1,874.20 **Benefit:** 75% = $1,405.65
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) **Fee:** $1,051.25 **Benefit:** 75% = $788.45
45568	TISSUE EXPANDER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.) **Fee:** $435.45 **Benefit:** 75% = $326.60
45569	CLOSURE OF ABDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, being a service associated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.) **Fee:** $664.95 **Benefit:** 75% = $498.75
45570	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.) **Fee:** $897.90 **Benefit:** 75% = $673.45 85% = $824.20

45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.) **Fee:** $286.25 **Benefit:** 75% = $214.70 85% = $243.35
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) **Fee:** $706.75 **Benefit:** 75% = $530.10 85% = $633.05
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) **Fee:** $818.50 **Benefit:** 75% = $613.90
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) **Fee:** $271.65 **Benefit:** 75% = $203.75 85% = $230.95
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.) *(See para T8.105 of explanatory notes to this Category)* **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
45585	LIPOSUCTION (suction assisted lipolysis) to 1 regional area, <u>not being a service associated with a service to which item 31521 or 31527 applies</u>, ***where it can be demonstrated*** that the treatment is for pathological lipodystrophy of hips, buttocks, thighs, knees or lower legs (Barraquer-Simon's Syndrome), gynaecomastia, lymphoedema or macrodystrophia lipomatosa (Anaes.) *(See para T8.105 of explanatory notes to this Category)* **Fee:** $619.95 **Benefit:** 75% = $465.00 85% = $546.25
45586	LIPOSUCTION (suction assisted lipolysis) for reduction of a buffalo hump, ***where it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition*** (Anaes.) *(See para T8.105 of explanatory notes to this Category)* **Fee:** $619.95 **Benefit:** 75% = $465.00
45587	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.) (Assist.) *(See para T8.106 of explanatory notes to this Category)* **Fee:** $874.25 **Benefit:** 75% = $655.70 85% = $800.55
45588	MELOPLASTY, (excluding browlifts and chinlift platysmaplasties), bilateral ***where it can be demonstrated*** that surgery is indicated because of congenital conditions, disease or trauma (other than trauma resulting from previous elective cosmetic surgery) (Anaes.) (Assist.) *(See para T8.106 of explanatory notes to this Category)* **Fee:** $1,311.50 **Benefit:** 75% = $983.65
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.) **Fee:** $474.25 **Benefit:** 75% = $355.70
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) **Fee:** $557.05 **Benefit:** 75% = $417.80
45596	MAXILLA, total resection of (Anaes.) (Assist.) **Fee:** $883.65 **Benefit:** 75% = $662.75
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) **Fee:** $1,182.90 **Benefit:** 75% = $887.20
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) **Fee:** $919.10 **Benefit:** 75% = $689.35 85% = $845.40
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) **Fee:** $686.40 **Benefit:** 75% = $514.80
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.) **Fee:** $811.85 **Benefit:** 75% = $608.90

45611	MANDIBLE, condylectomy (Anaes.) (Assist.) **Fee:** $464.90 **Benefit:** 75% = $348.70
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $502.95
45617	UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes.) *(See para T8.107 of explanatory notes to this Category)* **Fee:** $230.65 **Benefit:** 75% = $173.00 85% = $196.10
45620	LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes.) *(See para T8.107 of explanatory notes to this Category)* **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
45623	PTOSIS of eyelid (unilateral), correction of (Anaes.) (Assist.) **Fee:** $709.55 **Benefit:** 75% = $532.20 85% = $635.85
45624	PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes.) (Assist.) **Fee:** $919.90 **Benefit:** 75% = $689.95 85% = $846.20
45625	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital (Anaes.) **Fee:** $184.05 **Benefit:** 75% = $138.05
45626	ECTROPION OR ENTROPION, correction of (unilateral) (Anaes.) **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) **Fee:** $464.90 **Benefit:** 75% = $348.70 85% = $395.20
45632	RHINOPLASTY, correction of lateral or alar cartilages (Anaes.) **Fee:** $502.40 **Benefit:** 75% = $376.80 85% = $428.70
45635	RHINOPLASTY, correction of bony vault only (Anaes.) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $502.95
45638	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity ***(but not as a result of previous elective cosmetic surgery),*** or both (Anaes.) *(See para T8.108 of explanatory notes to this Category)* **Fee:** $995.15 **Benefit:** 75% = $746.40 85% = $921.45
45639	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, ***where it can be demonstrated*** that there is a need for correction of significant developmental deformity (Anaes.) *(See para T8.108 of explanatory notes to this Category)* **Fee:** $995.15 **Benefit:** 75% = $746.40 85% = $921.45
45641	RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes.) **Fee:** $1,062.70 **Benefit:** 75% = $797.05 85% = $989.00
45644	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,255.60 **Benefit:** 75% = $941.70 85% = $1,181.90
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) **Fee:** $219.45 **Benefit:** 75% = $164.60
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) **Fee:** $883.65 **Benefit:** 75% = $662.75 85% = $809.95
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.) *(See para T8.109 of explanatory notes to this Category)* **Fee:** $1,255.60 **Benefit:** 75% = $941.70

45650	RHINOPLASTY, secondary revision of (Anaes.) **Fee:** $145.05 **Benefit:** 75% = $108.80 85% = $123.30
45652	RHINOPHYMA, carbon dioxide laser or erbium laser excision-ablation of (Anaes.) **Fee:** $349.70 **Benefit:** 75% = $262.30 85% = $297.25
45653	RHINOPHYMA, shaving of (Anaes.) **Fee:** $349.70 **Benefit:** 75% = $262.30 85% = $297.25
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) **Fee:** $492.90 **Benefit:** 75% = $369.70 85% = $419.20
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes.) **Fee:** $511.55 **Benefit:** 75% = $383.70 85% = $437.85
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $2,825.05 **Benefit:** 75% = $2,118.80
45661	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) **Fee:** $1,255.60 **Benefit:** 75% = $941.70
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) **Fee:** $688.20 **Benefit:** 75% = $516.15
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
45668	VERMILIONECTOMY, by surgical excision (Anaes.) **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
45669	VERMILIONECTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.) *(See para T8.110 of explanatory notes to this Category)* **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $818.50 **Benefit:** 75% = $613.90 85% = $744.80
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $238.05 **Benefit:** 75% = $178.55 85% = $202.35
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) **Fee:** $474.25 **Benefit:** 75% = $355.70
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) **Fee:** $564.55 **Benefit:** 75% = $423.45
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $531.25 **Benefit:** 75% = $398.45
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $664.20 **Benefit:** 75% = $498.15
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) **Fee:** $737.85 **Benefit:** 75% = $553.40
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) **Fee:** $870.95 **Benefit:** 75% = $653.25
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) **Fee:** $256.85 **Benefit:** 75% = $192.65

45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) **Fee:** $479.65 **Benefit:** 75% = $359.75
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) **Fee:** $450.20 **Benefit:** 75% = $337.65
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) **Fee:** $811.85 **Benefit:** 75% = $608.90
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) **Fee:** $295.15 **Benefit:** 75% = $221.40 85% = $250.90
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) **Fee:** $767.35 **Benefit:** 75% = $575.55
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) **Fee:** $479.65 **Benefit:** 75% = $359.75
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) **Fee:** $546.20 **Benefit:** 75% = $409.65
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200, 45203 or 45239 applies (Anaes.) (Assist.) **Fee:** $767.35 **Benefit:** 75% = $575.55
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) **Fee:** $767.35 **Benefit:** 75% = $575.55
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and excluding services to which item 47933or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $948.75 **Benefit:** 75% = $711.60 85% = $875.05
45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,070.00 **Benefit:** 75% = $802.50
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,209.10 **Benefit:** 75% = $906.85
45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,357.85 **Benefit:** 75% = $1,018.40
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,376.55 **Benefit:** 75% = $1,032.45
45732	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,549.75 **Benefit:** 75% = $1,162.35

45735	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,581.00 **Benefit:** 75% = $1,185.75
45738	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,778.60 **Benefit:** 75% = $1,333.95
45741	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,739.25 **Benefit:** 75% = $1,304.45
45744	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,955.55 **Benefit:** 75% = $1,466.70
45747	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $1,897.50 **Benefit:** 75% = $1,423.15 85% = $1,823.80
45752	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) *(See para T8.111 of explanatory notes to this Category)* **Fee:** $2,125.35 **Benefit:** 75% = $1,594.05
45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) **Fee:** $2,138.00 **Benefit:** 75% = $1,603.50 85% = $2,064.30
45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) **Fee:** $2,562.90 **Benefit:** 75% = $1,922.20
45755	TEMPOROMANDIBULAR PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.) **Fee:** $360.90 **Benefit:** 75% = $270.70 85% = $306.80
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.) **Fee:** $645.80 **Benefit:** 75% = $484.35
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) *(See para T8.112 of explanatory notes to this Category)* **Fee:** $734.70 **Benefit:** 75% = $551.05
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.) **Fee:** $2,464.80 **Benefit:** 75% = $1,848.60 85% = $2,391.10
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.) **Fee:** $1,888.05 **Benefit:** 75% = $1,416.05
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.) **Fee:** $1,720.70 **Benefit:** 75% = $1,290.55 85% = $1,647.00

45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) **Fee:** $1,720.70 **Benefit:** 75% = $1,290.55
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) **Fee:** $1,265.10 **Benefit:** 75% = $948.85
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.) **Fee:** $967.30 **Benefit:** 75% = $725.50 85% = $893.60
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.) **Fee:** $1,637.00 **Benefit:** 75% = $1,227.75
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.) **Fee:** $1,618.35 **Benefit:** 75% = $1,213.80
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $874.25 **Benefit:** 75% = $655.70
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $494.45 **Benefit:** 75% = $370.85 85% = $420.75
45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.) **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
	ORAL AND MAXILLOFACIAL SURGERY
45799	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) **Fee:** $28.90 **Benefit:** 75% = $21.70 85% = $24.60
45801	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation),in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 45803 applies (Anaes.) *(See para T8.113 of explanatory notes to this Category)* **Fee:** $124.55 **Benefit:** 75% = $93.45 85% = $105.90
45803	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) *(See para T8.113 of explanatory notes to this Category)* **Fee:** $319.95 **Benefit:** 75% = $240.00 85% = $272.00
45805	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) *(See para T8.113 of explanatory notes to this Category)* **Fee:** $169.30 **Benefit:** 75% = $127.00 85% = $143.95
45807	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in this Subgroup applies, involving muscle, bone, or other deep tissue (Anaes.) *(See para T8.113 of explanatory notes to this Category)* **Fee:** $241.90 **Benefit:** 75% = $181.45 85% = $205.65

45809	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) *(See para T8.113 of explanatory notes to this Category)* **Fee:** $364.55 **Benefit:** 75% = $273.45 85% = $309.90
45811	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) *(See para T8.113 of explanatory notes to this Category)* **Fee:** $492.90 **Benefit:** 75% = $369.70 85% = $419.20
45813	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) *(See para T8.113 of explanatory notes to this Category)* **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $502.95
45815	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis - 1 bone or in combination with adjoining bones (Anaes.) (Assist.) **Fee:** $349.70 **Benefit:** 75% = $262.30 85% = $297.25
45817	OPERATION on SKULL for OSTEOMYELITIS (Anaes.) (Assist.) **Fee:** $455.85 **Benefit:** 75% = $341.90 85% = $387.50
45819	OPERATION ON ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND MAXILLOFACIAL REGION, being bones referred to in item 45817 (Anaes.) (Assist.) **Fee:** $576.60 **Benefit:** 75% = $432.45 85% = $502.90
45821	BONE GROWTH STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of (Anaes.) (Assist.) **Fee:** $373.70 **Benefit:** 75% = $280.30 85% = $317.65
45823	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $106.85 **Benefit:** 75% = $80.15 85% = $90.85
45825	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) **Fee:** $332.05 **Benefit:** 75% = $249.05 85% = $282.25
45827	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) **Fee:** $317.35 **Benefit:** 75% = $238.05 85% = $269.75
45829	MAXILLARY TUBEROSITY, reduction of (Anaes.) **Fee:** $242.10 **Benefit:** 75% = $181.60 85% = $205.80
45831	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) **Fee:** $317.35 **Benefit:** 75% = $238.05 85% = $269.75
45833	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) **Fee:** $398.50 **Benefit:** 75% = $298.90 85% = $338.75
45835	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) **Fee:** $494.45 **Benefit:** 75% = $370.85 85% = $420.75
45837	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) **Fee:** $575.55 **Benefit:** 75% = $431.70 85% = $501.85
45839	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) **Fee:** $575.55 **Benefit:** 75% = $431.70 85% = $501.85
45841	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) **Fee:** $464.80 **Benefit:** 75% = $348.60 85% = $395.10
45843	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) **Fee:** $285.10 **Benefit:** 75% = $213.85 85% = $242.35

45845	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $494.45 **Benefit:** 75% = $370.85 85% = $420.75
45847	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) **Fee:** $183.00 **Benefit:** 75% = $137.25 85% = $155.55
45849	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) **Fee:** $570.05 **Benefit:** 75% = $427.55 85% = $496.35
45851	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) **Fee:** $140.30 **Benefit:** 75% = $105.25 85% = $119.30
45853	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) **Fee:** $874.25 **Benefit:** 75% = $655.70 85% = $800.55
45855	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) **Fee:** $401.10 **Benefit:** 75% = $300.85 85% = $340.95
45857	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.) **Fee:** $641.60 **Benefit:** 75% = $481.20 85% = $567.90
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60 85% = $274.95
45861	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $856.05 **Benefit:** 75% = $642.05 85% = $782.35
45863	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $948.95 **Benefit:** 75% = $711.75 85% = $875.25
45865	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) **Fee:** $285.10 **Benefit:** 75% = $213.85 85% = $242.35
45867	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $306.50 **Benefit:** 75% = $229.90 85% = $260.55
45869	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including partial or total meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,166.05 **Benefit:** 75% = $874.55 85% = $1,092.35
45871	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,313.50 **Benefit:** 75% = $985.15 85% = $1,239.80
45873	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 45863, 45867, 45869 and 45871 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) **Fee:** $1,476.00 **Benefit:** 75% = $1,107.00 85% = $1,402.30
45875	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45 85% = $392.65

45877	TEMPOROMANDIBULAR JOINT, arthrodesis of, with synovectomy if performed, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45 85% = $392.65
45879	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $306.50 **Benefit:** 75% = $229.90 85% = $260.55
45882	The treatment of a premalignant lesion of the oral mucosa by a treatment using cryotherapy, diathermy or carbon dioxide laser. **Fee:** $42.20 **Benefit:** 75% = $31.65 85% = $35.90
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.) **Fee:** $435.45 **Benefit:** 75% = $326.60 85% = $370.15
45888	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) **Fee:** $405.85 **Benefit:** 75% = $304.40 85% = $345.00
45891	SINGLE-STAGE LOCAL FLAP where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) **Fee:** $591.20 **Benefit:** 75% = $443.40 85% = $517.50
45894	FREE GRAFTING, in the oral and maxillofacial region, (mucosa or split skin) of a granulating area (Anaes.) **Fee:** $200.90 **Benefit:** 75% = $150.70 85% = $170.80
45897	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) **Fee:** $1,049.15 **Benefit:** 75% = $786.90 85% = $975.45
45900	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $236.65 **Benefit:** 75% = $177.50 85% = $201.20
45939	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) **Fee:** $438.75 **Benefit:** 75% = $329.10 85% = $372.95
45945	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) **Fee:** $116.50 **Benefit:** 75% = $87.40 85% = $99.05
45975	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting *(See para T8.114 of explanatory notes to this Category)* **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
45978	MANDIBLE, treatment of fracture of, not requiring splinting *(See para T8.114 of explanatory notes to this Category)* **Fee:** $154.90 **Benefit:** 75% = $116.20 85% = $131.70
45981	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction *(See para T8.114 of explanatory notes to this Category)* **Fee:** $84.05 **Benefit:** 75% = $63.05 85% = $71.45
45984	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para T8.114 of explanatory notes to this Category)* **Fee:** $605.15 **Benefit:** 75% = $453.90 85% = $531.45
45987	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) *(See para T8.114 of explanatory notes to this Category)* **Fee:** $605.15 **Benefit:** 75% = $453.90 85% = $531.45
45990	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para T8.114 of explanatory notes to this Category)* **Fee:** $826.55 **Benefit:** 75% = $619.95 85% = $752.85

45993	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) *(See para T8.114 of explanatory notes to this Category)* **Fee:** $826.55 **Benefit:** 75% = $619.95 85% = $752.85
45996	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) *(See para T8.114 of explanatory notes to this Category)* **Fee:** $234.35 **Benefit:** 75% = $175.80 85% = $199.20
	SUBGROUP 14 - HAND SURGERY
46300	*Note: Items 46300 to 46534 are restricted to surgery on the hand/s.* INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $332.10 **Benefit:** 75% = $249.10
46303	CARPOMETACARPAL JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $369.10 **Benefit:** 75% = $276.85
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $516.70 **Benefit:** 75% = $387.55
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) **Fee:** $516.70 **Benefit:** 75% = $387.55
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.) **Fee:** $516.70 **Benefit:** 75% = $387.55
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.) **Fee:** $664.35 **Benefit:** 75% = $498.30
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.) **Fee:** $885.70 **Benefit:** 75% = $664.30
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.) **Fee:** $1,107.20 **Benefit:** 75% = $830.40
46321	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.) (Assist.) **Fee:** $1,328.65 **Benefit:** 75% = $996.50 85% = $1,254.95
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $792.30 **Benefit:** 75% = $594.25
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.) **Fee:** $826.80 **Benefit:** 75% = $620.10
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.) **Fee:** $199.35 **Benefit:** 75% = $149.55 85% = $169.45
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular repair with or without arthrotomy (Anaes.) (Assist.) **Fee:** $339.65 **Benefit:** 75% = $254.75
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.) **Fee:** $553.55 **Benefit:** 75% = $415.20

46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.) **Fee:** $258.40 **Benefit:** 75% = $193.80 85% = $219.65
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.) **Fee:** $457.50 **Benefit:** 75% = $343.15 85% = $388.90
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.) **Fee:** $457.50 **Benefit:** 75% = $343.15
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.) **Fee:** $553.55 **Benefit:** 75% = $415.20
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) **Fee:** $239.90 **Benefit:** 75% = $179.95 85% = $203.95
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.) **Fee:** $358.00 **Benefit:** 75% = $268.50
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.) **Fee:** $479.75 **Benefit:** 75% = $359.85
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.) **Fee:** $597.85 **Benefit:** 75% = $448.40 85% = $524.15
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.) **Fee:** $719.70 **Benefit:** 75% = $539.80
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.) **Fee:** $206.65 **Benefit:** 75% = $155.00 85% = $175.70
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.) **Fee:** $125.50 **Benefit:** 75% = $94.15 85% = $106.70
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.) **Fee:** $206.65 **Benefit:** 75% = $155.00 85% = $175.70
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $419.95 **Benefit:** 75% = $315.00 85% = $357.00
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $498.25 **Benefit:** 75% = $373.70 85% = $424.55
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (Anaes.) (Assist.) **Fee:** $664.35 **Benefit:** 75% = $498.30
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (Anaes.) (Assist.) **Fee:** $295.20 **Benefit:** 75% = $221.40
46384	Z PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (Anaes.) (Assist.) **Fee:** $295.20 **Benefit:** 75% = $221.40
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.) **Fee:** $609.05 **Benefit:** 75% = $456.80 85% = $535.35
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $812.05 **Benefit:** 75% = $609.05
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (Anaes.) (Assist.) **Fee:** $941.10 **Benefit:** 75% = $705.85

46396	PHALANX OR METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60 85% = $274.95
46399	PHALANX OR METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.) (Assist.) **Fee:** $508.15 **Benefit:** 75% = $381.15
46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (Anaes.) (Assist.) **Fee:** $508.15 **Benefit:** 75% = $381.15
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (Anaes.) (Assist.) **Fee:** $620.10 **Benefit:** 75% = $465.10
46408	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.) **Fee:** $679.10 **Benefit:** 75% = $509.35
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (Anaes.) (Assist.) **Fee:** $398.60 **Benefit:** 75% = $298.95
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.) (Assist.) **Fee:** $516.60 **Benefit:** 75% = $387.45 85% = $442.90
46417	TENDON transfer for restoration of hand function, each transfer (Anaes.) (Assist.) **Fee:** $479.75 **Benefit:** 75% = $359.85
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.) **Fee:** $200.80 **Benefit:** 75% = $150.60 85% = $170.70
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.) **Fee:** $321.05 **Benefit:** 75% = $240.80 85% = $272.90
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $332.10 **Benefit:** 75% = $249.10
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $405.95 **Benefit:** 75% = $304.50 85% = $345.10
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $442.95 **Benefit:** 75% = $332.25
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) **Fee:** $516.70 **Benefit:** 75% = $387.55
46438	MALLET FINGER, closed pin fixation of (Anaes.) **Fee:** $132.90 **Benefit:** 75% = $99.70 85% = $113.00
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) **Fee:** $321.05 **Benefit:** 75% = $240.80 85% = $272.90
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) **Fee:** $275.60 **Benefit:** 75% = $206.70
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $479.75 **Benefit:** 75% = $359.85
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) **Fee:** $597.85 **Benefit:** 75% = $448.40
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.) **Fee:** $369.10 **Benefit:** 75% = $276.85

46456	FINGER, percutaneous tenotomy of (Anaes.) **Fee:** $96.00 **Benefit:** 75% = $72.00 85% = $81.60
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.) **Fee:** $184.55 **Benefit:** 75% = $138.45 85% = $156.90
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.) **Fee:** $295.20 **Benefit:** 75% = $221.40 85% = $250.95
46464	AMPUTATION of a supernumerary complete digit (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30
46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $387.55 **Benefit:** 75% = $290.70
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $553.55 **Benefit:** 75% = $415.20 85% = $479.85
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $719.70 **Benefit:** 75% = $539.80
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) **Fee:** $885.70 **Benefit:** 75% = $664.30
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.) **Fee:** $369.10 **Benefit:** 75% = $276.85 85% = $313.75
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.) **Fee:** $295.20 **Benefit:** 75% = $221.40 85% = $250.95
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $221.50 **Benefit:** 75% = $166.15 85% = $188.30
46489	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $258.40 **Benefit:** 75% = $193.80 85% = $219.65
46492	CONTRACTURE OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper than skin and subcutaneous tissue (Anaes.) (Assist.) **Fee:** $354.30 **Benefit:** 75% = $265.75
46494	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $215.85 **Benefit:** 75% = $161.90 85% = $183.50
46495	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) **Fee:** $199.35 **Benefit:** 75% = $149.55 85% = $169.45
46498	GANGLION OF FLEXOR TENDON SHEATH, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) **Fee:** $215.85 **Benefit:** 75% = $161.90 85% = $183.50
46500	GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $258.40 **Benefit:** 75% = $193.80 85% = $219.65

46501	GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $323.05 **Benefit:** 75% = $242.30 85% = $274.60
46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $297.30 **Benefit:** 75% = $223.00 85% = $252.75
46503	RECURRENT GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes.) (Assist.) **Fee:** $371.35 **Benefit:** 75% = $278.55 85% = $315.65
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.) **Fee:** $1,084.95 **Benefit:** 75% = $813.75 85% = $1,011.25
46507	DIGIT OR RAY, transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.) **Fee:** $1,262.20 **Benefit:** 75% = $946.65
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.) **Fee:** $344.45 **Benefit:** 75% = $258.35
46513	DIGITAL NAIL OF FINGER OR THUMB, removal of, not being a service to which item 46516 applies (Anaes.) **Fee:** $55.45 **Benefit:** 75% = $41.60 85% = $47.15
46516	DIGITAL NAIL OF FINGER OR THUMB, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
46519	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
46522	FLEXOR TENDON SHEATH OF FINGER OR THUMB, open operation and drainage for infection (Anaes.) (Assist.) **Fee:** $413.35 **Benefit:** 75% = $310.05
46525	PULP SPACE INFECTION, PARONYCHIA OF HAND, incision for, when performed in an operating theatre of a hospital, not being a service to which another item in this Group applies (excluding after-care) (Anaes.) **Fee:** $55.45 **Benefit:** 75% = $41.60 85% = $47.15
46528	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
	SUBGROUP 15 - ORTHOPAEDIC
	TREATMENT OF DISLOCATIONS
47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $69.35 **Benefit:** 75% = $52.05 85% = $58.95
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $83.20 **Benefit:** 75% = $62.40 85% = $70.75
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $167.10 **Benefit:** 75% = $125.35 85% = $142.05
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.) **Fee:** $332.55 **Benefit:** 75% = $249.45

47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia **Fee:** $83.20 **Benefit:** 75% = $62.40 85% = $70.75
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $193.90 **Benefit:** 75% = $145.45 85% = $164.85
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) **Fee:** $193.90 **Benefit:** 75% = $145.45 85% = $164.85
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $193.90 **Benefit:** 75% = $145.45 85% = $164.85
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05 85% = $219.90
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $83.20 **Benefit:** 75% = $62.40 85% = $70.75
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $147.95 **Benefit:** 75% = $111.00 85% = $125.80
47048	HIP, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $318.75 **Benefit:** 75% = $239.10 85% = $270.95
47051	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.) **Fee:** $318.75 **Benefit:** 75% = $239.10 85% = $270.95
47057	PATELLA, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
47060	PATELLA, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $249.45 **Benefit:** 75% = $187.10 85% = $212.05
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.) **Fee:** $332.55 **Benefit:** 75% = $249.45
47069	TOE, treatment of dislocation of, by closed reduction (Anaes.) **Fee:** $69.35 **Benefit:** 75% = $52.05 85% = $58.95
47072	TOE, treatment of dislocation of, by open reduction (Anaes.) **Fee:** $92.25 **Benefit:** 75% = $69.20 85% = $78.45

	TREATMENT OF FRACTURES
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.) **Fee:** $83.20 **Benefit:** 75% = $62.40 85% = $70.75
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes.) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $124.65 **Benefit:** 75% = $93.50 85% = $106.00
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $143.25 **Benefit:** 75% = $107.45 85% = $121.80
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes.) **Fee:** $207.80 **Benefit:** 75% = $155.85
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $193.90 **Benefit:** 75% = $145.45 85% = $164.85
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85
47336	METACARPAL, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes.) **Fee:** $193.90 **Benefit:** 75% = $145.45 85% = $164.85
47342	METACARPAL, treatment of fracture of, by open reduction (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) **Fee:** $92.25 **Benefit:** 75% = $69.20 85% = $78.45
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $314.15
47360	RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (Anaes.) **Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00

47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $193.90 **Benefit:** 75% = $145.45 85% = $164.85
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05 85% = $219.90
47369	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $249.45 **Benefit:** 75% = $187.10 85% = $212.05
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $332.55 **Benefit:** 75% = $249.45
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $286.30 **Benefit:** 75% = $214.75 85% = $243.40
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45
47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $401.90 **Benefit:** 75% = $301.45
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $535.80 **Benefit:** 75% = $401.85
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) **Fee:** $184.70 **Benefit:** 75% = $138.55 85% = $157.00
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55
47405	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.) **Fee:** $184.70 **Benefit:** 75% = $138.55 85% = $157.00
47408	RADIUS, treatment of fracture of head or neck of, open reduction of, including internal fixation and excision where performed (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15

47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05 85% = $219.90
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $508.15 **Benefit:** 75% = $381.15
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) **Fee:** $212.45 **Benefit:** 75% = $159.35 85% = $180.60
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $318.75 **Benefit:** 75% = $239.10 85% = $270.95
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $531.20 **Benefit:** 75% = $398.40
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) **Fee:** $406.55 **Benefit:** 75% = $304.95 85% = $345.60
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $646.85 **Benefit:** 75% = $485.15
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) **Fee:** $808.40 **Benefit:** 75% = $606.30
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $332.55 **Benefit:** 75% = $249.45
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) **Fee:** $443.50 **Benefit:** 75% = $332.65
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) **Fee:** $534.65 **Benefit:** 75% = $401.00
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05 85% = $219.90
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) **Fee:** $388.15 **Benefit:** 75% = $291.15 85% = $329.95
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $517.40 **Benefit:** 75% = $388.05
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47467	STERNUM, treatment of fracture of, by open reduction (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35

47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70 85% = $361.20
47471	RIBS (1 or more), treatment of fracture of - each attendance **Fee:** $42.20 **Benefit:** 75% = $31.65 85% = $35.90
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum **Fee:** $184.70 **Benefit:** 75% = $138.55 85% = $157.00
47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.) **Fee:** $554.30 **Benefit:** 75% = $415.75
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.) **Fee:** $1,385.85 **Benefit:** 75% = $1,039.40
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45 85% = $392.65
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.) **Fee:** $692.90 **Benefit:** 75% = $519.70
47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,385.85 **Benefit:** 75% = $1,039.40 85% = $1,312.15
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,385.85 **Benefit:** 75% = $1,039.40
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $1,385.85 **Benefit:** 75% = $1,039.40
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70 85% = $361.20
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $850.05 **Benefit:** 75% = $637.55

47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.) **Fee:** $850.05 **Benefit:** 75% = $637.55
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $942.35 **Benefit:** 75% = $706.80
47534	FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70 85% = $361.20
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) **Fee:** $212.45 **Benefit:** 75% = $159.35 85% = $180.60
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) **Fee:** $332.55 **Benefit:** 75% = $249.45 85% = $282.70
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $443.50 **Benefit:** 75% = $332.65
47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $314.15
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) **Fee:** $554.30 **Benefit:** 75% = $415.75
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (Anaes.) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) **Fee:** $401.90 **Benefit:** 75% = $301.45 85% = $341.65
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) **Fee:** $699.10 **Benefit:** 75% = $524.35
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.) **Fee:** $891.10 **Benefit:** 75% = $668.35
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $466.50 **Benefit:** 75% = $349.90 85% = $396.55
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) **Fee:** $535.80 **Benefit:** 75% = $401.85 85% = $462.10
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.) **Fee:** $669.80 **Benefit:** 75% = $502.35

47576	FIBULA, treatment of fracture of (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) **Fee:** $157.05 **Benefit:** 75% = $117.80 85% = $133.50
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) **Fee:** $415.85 **Benefit:** 75% = $311.90
47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
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.) **Fee:** $1,570.80 **Benefit:** 75% = $1,178.10
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) **Fee:** $212.45 **Benefit:** 75% = $159.35 85% = $180.60
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $318.75 **Benefit:** 75% = $239.10 85% = $270.95
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) **Fee:** $554.30 **Benefit:** 75% = $415.75
47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $346.45 **Benefit:** 75% = $259.85 85% = $294.50
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $401.90 **Benefit:** 75% = $301.45 85% = $341.65
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45 85% = $392.65
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $577.50 **Benefit:** 75% = $433.15
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $401.90 **Benefit:** 75% = $301.45 85% = $341.65
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $554.30 **Benefit:** 75% = $415.75
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) **Fee:** $157.05 **Benefit:** 75% = $117.80 85% = $133.50
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) **Fee:** $332.55 **Benefit:** 75% = $249.45 85% = $282.70
47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15

47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) **Fee:** $147.95 **Benefit:** 75% = $111.00 85% = $125.80
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $221.80 **Benefit:** 75% = $166.35 85% = $188.55
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $295.45 **Benefit:** 75% = $221.60
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) **Fee:** $346.45 **Benefit:** 75% = $259.85 85% = $294.50
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance **Fee:** $42.20 **Benefit:** 75% = $31.65 85% = $35.90
47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, with immobilisation by calipers or halo (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40 85% = $665.50
47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, with immobilisation by calipers or halo, and including up to 14 days post-operative care (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation (Anaes.) (Assist.) **Fee:** $1,016.25 **Benefit:** 75% = $762.20
47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, with immobilisation by calipers or halo, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
47696	SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $314.15
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.) **Fee:** $1,478.35 **Benefit:** 75% = $1,108.80
47702	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Anaes.) (Assist.) **Fee:** $1,847.85 **Benefit:** 75% = $1,385.90

47703	SKULL, treatment of fracture of, each attendance **Fee:** $42.20 **Benefit:** 75% = $31.65 85% = $35.90
47705	SKULL CALIPERS, insertion of, as an independent procedure (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85
47708	PLASTER JACKET, application of, as an independent procedure (Anaes.) **Fee:** $212.45 **Benefit:** 75% = $159.35 85% = $180.60
47711	HALO, application of, as an independent procedure (Anaes.) (Assist.) **Fee:** $314.20 **Benefit:** 75% = $235.65
47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) **Fee:** $235.55 **Benefit:** 75% = $176.70
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes.) (Assist.) **Fee:** $415.85 **Benefit:** 75% = $311.90
47720	HALO-FEMORAL TRACTION, as an independent procedure (Anaes.) (Assist.) **Fee:** $415.85 **Benefit:** 75% = $311.90 85% = $353.50
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes.) (Assist.) **Fee:** $415.85 **Benefit:** 75% = $311.90 85% = $353.50
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) **Fee:** $138.60 **Benefit:** 75% = $103.95
47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance **Fee:** $42.25 **Benefit:** 75% = $31.70 85% = $35.95
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) **Fee:** $471.40 **Benefit:** 75% = $353.55
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $399.05 **Benefit:** 75% = $299.30
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) **Fee:** $399.05 **Benefit:** 75% = $299.30
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) **Fee:** $234.35 **Benefit:** 75% = $175.80 85% = $199.20
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) **Fee:** $384.80 **Benefit:** 75% = $288.60
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) **Fee:** $471.40 **Benefit:** 75% = $353.55
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) **Fee:** $541.55 **Benefit:** 75% = $406.20
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) **Fee:** $427.55 **Benefit:** 75% = $320.70

47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) **Fee:** $427.55 **Benefit:** 75% = $320.70
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $555.80 **Benefit:** 75% = $416.85
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) **Fee:** $555.80 **Benefit:** 75% = $416.85 85% = $482.10
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $705.35 **Benefit:** 75% = $529.05
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) **Fee:** $705.35 **Benefit:** 75% = $529.05
	GENERAL
47900	BONE CYST, injection into or aspiration of (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47903	EPICONDYLITIS, open operation for (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) **Fee:** $55.45 **Benefit:** 75% = $41.60 85% = $47.15
47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47912	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.) **Fee:** $55.45 **Benefit:** 75% = $41.60 85% = $47.15
47915	INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
47916	INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) **Fee:** $373.70 **Benefit:** 75% = $280.30
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.) **Fee:** $110.75 **Benefit:** 75% = $83.10 85% = $94.15
47924	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.) **Fee:** $36.95 **Benefit:** 75% = $27.75 85% = $31.45
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital - per bone (Anaes.) **Fee:** $138.60 **Benefit:** 75% = $103.95
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05
47933	SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision of, or simple removal of bunion and any associated bursa, not being a service associated with a service for removal of bursa (Anaes.) *(See para T8.116 of explanatory notes to this Category)* **Fee:** $203.15 **Benefit:** 75% = $152.40 85% = $172.70

47936	LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Anaes.) (Assist.) *(See para T8.116 of explanatory notes to this Category)* **Fee:** $249.45 **Benefit:** 75% = $187.10
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.) **Fee:** $157.05 **Benefit:** 75% = $117.80
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) **Fee:** $184.70 **Benefit:** 75% = $138.55 85% = $157.00
47954	TENDON, repair of, as an independent procedure (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $314.15
47957	TENDON, large, lengthening of, as an independent procedure (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) **Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) **Fee:** $212.45 **Benefit:** 75% = $159.35 85% = $180.60
47966	TENDON OR LIGAMENT, TRANSFER, as an independent procedure (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $258.70 **Benefit:** 75% = $194.05
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) **Fee:** $206.65 **Benefit:** 75% = $155.00
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.) **Fee:** $362.25 **Benefit:** 75% = $271.70
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) **Fee:** $220.00 **Benefit:** 75% = $165.00
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.) **Fee:** $147.75 **Benefit:** 75% = $110.85 85% = $125.60
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.) **Fee:** $358.10 **Benefit:** 75% = $268.60
	BONE GRAFTS
48200	FEMUR, bone graft to (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $896.20 **Benefit:** 75% = $672.15
48206	TIBIA, bone graft to (Anaes.) (Assist.) **Fee:** $554.90 **Benefit:** 75% = $416.20
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $711.45 **Benefit:** 75% = $533.60
48212	HUMERUS, bone graft to (Anaes.) (Assist.) **Fee:** $554.90 **Benefit:** 75% = $416.20
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.) **Fee:** $711.45 **Benefit:** 75% = $533.60

48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $554.90 **Benefit:** 75% = $416.20
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) **Fee:** $480.40 **Benefit:** 75% = $360.30
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.) **Fee:** $415.85 **Benefit:** 75% = $311.90
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.) **Fee:** $785.30 **Benefit:** 75% = $589.00
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $434.20 **Benefit:** 75% = $325.65
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
	OSTEOTOMY AND OSTEECTOMY
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $508.15 **Benefit:** 75% = $381.15
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $508.15 **Benefit:** 75% = $381.15
48412	HUMERUS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $618.90 **Benefit:** 75% = $464.20
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $785.30 **Benefit:** 75% = $589.00
48418	TIBIA, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $618.90 **Benefit:** 75% = $464.20 85% = $545.20
48421	TIBIA, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $785.30 **Benefit:** 75% = $589.00
48424	FEMUR OR PELVIS, osteotomy or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.) **Fee:** $896.20 **Benefit:** 75% = $672.15

	EPIPHYSEODESIS
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) **Fee:** $480.40 **Benefit:** 75% = $360.30
48509	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.) **Fee:** $231.10 **Benefit:** 75% = $173.35
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.) **Fee:** $877.70 **Benefit:** 75% = $658.30
	SPINE
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital (Anaes.) **Fee:** $92.25 **Benefit:** 75% = $69.20
48603	SPINE, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital, not being a service associated with a service to which item 48600 or 50115 applies (Anaes.) **Fee:** $138.60 **Benefit:** 75% = $103.95 85% = $117.85
48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes.) (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.) (Assist.) **Fee:** $2,402.20 **Benefit:** 75% = $1,801.65
48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) **Fee:** $3,416.90 **Benefit:** 75% = $2,562.70
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.) (Assist.) **Fee:** $434.20 **Benefit:** 75% = $325.65
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.) (Assist.) **Fee:** $2,402.20 **Benefit:** 75% = $1,801.65
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.) (Assist.) **Fee:** $1,570.80 **Benefit:** 75% = $1,178.10
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) **Fee:** $1,940.35 **Benefit:** 75% = $1,455.30
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.) (Assist.) **Fee:** $2,494.45 **Benefit:** 75% = $1,870.85
48630	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Anaes.) (Assist.) **Fee:** $2,771.70 **Benefit:** 75% = $2,078.80
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes.) (Assist.) **Fee:** $1,532.20 **Benefit:** 75% = $1,149.15

48636	PERCUTANEOUS LUMBAR PARTIAL OR TOTAL DISCECTOMY, 1 or more levels, not being a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.) *(See para T8.117 of explanatory notes to this Category)* **Fee:** $794.45 **Benefit:** 75% = $595.85 85% = $720.75
48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.) (Assist.) **Fee:** $1,339.55 **Benefit:** 75% = $1,004.70
48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) **Fee:** $3,416.90 **Benefit:** 75% = $2,562.70
48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.) (Assist.) **Fee:** $785.30 **Benefit:** 75% = $589.00
48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.) (Assist.) **Fee:** $1,478.35 **Benefit:** 75% = $1,108.80
48654	SPINAL FUSION (posterior interbody), with partial or total laminectomy, 1 level (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
48657	SPINAL FUSION (posterior interbody), with partial or total laminectomy, more than 1 level (Anaes.) (Assist.) **Fee:** $1,478.35 **Benefit:** 75% = $1,108.80
48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $1,062.50 **Benefit:** 75% = $796.90
48663	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $794.45 **Benefit:** 75% = $595.85
48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $480.40 **Benefit:** 75% = $360.30
48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $1,432.00 **Benefit:** 75% = $1,074.00
48672	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $1,071.90 **Benefit:** 75% = $803.95
48675	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) *(See para T8.118 of explanatory notes to this Category)* **Fee:** $646.85 **Benefit:** 75% = $485.15
48678	SPINE, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes.) (Assist.) *(See para T8.119 of explanatory notes to this Category)* **Fee:** $554.90 **Benefit:** 75% = $416.20

48681	SPINE, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.119 of explanatory notes to this Category)* **Fee:** $923.90 **Benefit:** 75% = $692.95
48684	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels, not being a service associated with artificial intervertebral total disc replacement (Anaes.) (Assist.) *(See para T8.119 of explanatory notes to this Category)* **Fee:** $923.90 **Benefit:** 75% = $692.95
48687	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Anaes.) (Assist.) *(See para T8.119 of explanatory notes to this Category)* **Fee:** $1,293.25 **Benefit:** 75% = $969.95
48690	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Anaes.) (Assist.) *(See para T8.119 of explanatory notes to this Category)* **Fee:** $1,478.35 **Benefit:** 75% = $1,108.80
48691	LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (Anaes.) (Assist.) **Fee:** $1,760.20 **Benefit:** 75% = $1,320.15 85% = $1,686.50
48692	LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, with fluoroscopy (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) **Fee:** $1,186.40 **Benefit:** 75% = $889.80 85% = $1,112.70
48693	LUMBAR ARTIFICIAL INTERVERTEBRAL TOTAL DISC REPLACEMENT including removal of disc, 1 level, in patients with single-level intralumbar disc disease in the absence of vertebral osteoporosis and prior spinal fusion at the same lumbar level who have failed conservative therapy, (where an assisting surgeon performs the approach) - assisting surgeon (Anaes.) (Assist.) **Fee:** $573.80 **Benefit:** 75% = $430.35 85% = $500.10
	SHOULDER
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85 85% = $235.55
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.) **Fee:** $554.30 **Benefit:** 75% = $415.75
48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.) (Assist.) **Fee:** $554.30 **Benefit:** 75% = $415.75
48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
48912	SHOULDER, arthrotomy of (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60 85% = $274.95
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.) **Fee:** $1,478.35 **Benefit:** 75% = $1,108.80
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.) **Fee:** $1,524.45 **Benefit:** 75% = $1,143.35

48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.) **Fee:** $1,755.50 **Benefit:** 75% = $1,316.65
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.) **Fee:** $360.20 **Benefit:** 75% = $270.15
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.) **Fee:** $970.10 **Benefit:** 75% = $727.60
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
48939	SHOULDER, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
48942	SHOULDER, arthrodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.) **Fee:** $1,385.85 **Benefit:** 75% = $1,039.40
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $877.70 **Benefit:** 75% = $658.30
48954	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
	ELBOW
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $692.90 **Benefit:** 75% = $519.70
49106	ELBOW, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95 85% = $850.20
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) **Fee:** $692.90 **Benefit:** 75% = $519.70
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) **Fee:** $692.90 **Benefit:** 75% = $519.70

49115	ELBOW, total joint replacement of (Anaes.) (Assist.) **Fee:** $1,108.60 **Benefit:** 75% = $831.45
49116	ELBOW, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,463.35 **Benefit:** 75% = $1,097.55
49117	ELBOW, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,756.00 **Benefit:** 75% = $1,317.00
49118	ELBOW, diagnostic arthroscopy of, including biopsy and lavage, not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90
49121	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
	WRIST
49200	WRIST, arthrodesis of, with synovectomy if performed, with or without bone graft and internal fixation of the radiocarpal joint (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $803.70 **Benefit:** 75% = $602.80
49203	WRIST, limited arthrodesis of the intercarpal joint, with synovectomy if performed, with or without bone graft (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $600.50 **Benefit:** 75% = $450.40
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $554.30 **Benefit:** 75% = $415.75
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $739.20 **Benefit:** 75% = $554.40
49210	WRIST, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $975.75 **Benefit:** 75% = $731.85
49211	WRIST, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,170.90 **Benefit:** 75% = $878.20
49212	WRIST, arthrotomy of (Anaes.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $231.10 **Benefit:** 75% = $173.35
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $637.60 **Benefit:** 75% = $478.20
49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $267.85 **Benefit:** 75% = $200.90
49221	WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $600.50 **Benefit:** 75% = $450.40

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.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $692.90 **Benefit:** 75% = $519.70
49227	WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) *(See para T8.120 of explanatory notes to this Category)* **Fee:** $692.90 **Benefit:** 75% = $519.70
	HIP
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) **Fee:** $511.55 **Benefit:** 75% = $383.70
49303	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.) (Assist.) **Fee:** $535.80 **Benefit:** 75% = $401.85
49306	HIP arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.) **Fee:** $831.55 **Benefit:** 75% = $623.70
49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,272.15 **Benefit:** 75% = $1,704.15
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,570.80 **Benefit:** 75% = $1,178.10
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,847.85 **Benefit:** 75% = $1,385.90
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,125.00 **Benefit:** 75% = $1,593.75
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,125.00 **Benefit:** 75% = $1,593.75
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.) **Fee:** $2,402.20 **Benefit:** 75% = $1,801.65
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.) **Fee:** $351.05 **Benefit:** 75% = $263.30
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.) **Fee:** $2,725.50 **Benefit:** 75% = $2,044.15
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.) **Fee:** $2,725.50 **Benefit:** 75% = $2,044.15

49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.) **Fee:** $3,233.65 **Benefit:** 75% = $2,425.25
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.) **Fee:** $831.55 **Benefit:** 75% = $623.70
49360	HIP, diagnostic arthroscopy of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $337.55 **Benefit:** 75% = $253.20
49363	HIP, diagnostic arthroscopy of, with synovial biopsy, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $406.50 **Benefit:** 75% = $304.90 85% = $345.55
49366	HIP, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the hip (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
	KNEE
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
49503	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) – any 1 procedure (Anaes.) (Assist.) **Fee:** $480.40 **Benefit:** 75% = $360.30
49506	KNEE, partial or total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not being a service to which another item in this Group applies) – any 2 or more procedures (Anaes.) (Assist.) **Fee:** $720.70 **Benefit:** 75% = $540.55
49509	KNEE, total synovectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
49512	KNEE, arthrodesis of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,062.50 **Benefit:** 75% = $796.90
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.) **Fee:** $831.55 **Benefit:** 75% = $623.70
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.) **Fee:** $1,183.85 **Benefit:** 75% = $887.90
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) **Fee:** $2,272.15 **Benefit:** 75% = $1,704.15
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,570.80 **Benefit:** 75% = $1,178.10
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.) **Fee:** $1,847.85 **Benefit:** 75% = $1,385.90
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,570.80 **Benefit:** 75% = $1,178.10
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,940.35 **Benefit:** 75% = $1,455.30

49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) **Fee:** $2,217.50 **Benefit:** 75% = $1,663.15
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.) **Fee:** $441.15 **Benefit:** 75% = $330.90
49536	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
49539	KNEE, reconstructive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies or a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
49542	KNEE, reconstructive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
49545	KNEE, revision arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.) **Fee:** $923.90 **Benefit:** 75% = $692.95
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.) **Fee:** $1,293.25 **Benefit:** 75% = $969.95
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.) **Fee:** $1,847.85 **Benefit:** 75% = $1,385.90
49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.) *(See para T8.121 of explanatory notes to this Category)* **Fee:** $267.85 **Benefit:** 75% = $200.90
49558	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90
49559	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $401.10 **Benefit:** 75% = $300.85
49560	KNEE, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release – not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $541.30 **Benefit:** 75% = $406.00
49561	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty – not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $661.45 **Benefit:** 75% = $496.10
49562	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty – not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) **Fee:** $721.80 **Benefit:** 75% = $541.35

49563	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft (excluding autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation) –not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) *(See para T8.121 of explanatory notes to this Category)* **Fee:** $781.85 **Benefit:** 75% = $586.40
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $901.90 **Benefit:** 75% = $676.45
49566	KNEE, arthroscopic total synovectomy of, not being a service associated with any other arthroscopic procedure of the knee (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
	ANKLE
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90
49703	ANKLE, arthroscopic surgery of, not being a service associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.) **Fee:** $692.90 **Benefit:** 75% = $519.70
49712	ANKLE, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
49715	ANKLE, total joint replacement of (Anaes.) (Assist.) **Fee:** $1,108.60 **Benefit:** 75% = $831.45
49716	ANKLE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,463.35 **Benefit:** 75% = $1,097.55
49717	ANKLE, total replacement arthroplasty of, revision procedure, requiring bone grafting, including removal of prosthesis (Anaes.) (Assist.) **Fee:** $1,756.00 **Benefit:** 75% = $1,317.00
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment **Fee:** $231.10 **Benefit:** 75% = $173.35 85% = $196.45
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) **Fee:** $646.85 **Benefit:** 75% = $485.15
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85
49728	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.) **Fee:** $554.15 **Benefit:** 75% = $415.65
	FOOT
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) **Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00

49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) **Fee:** $166.35 **Benefit:** 75% = $124.80 85% = $141.40
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) **Fee:** $129.40 **Benefit:** 75% = $97.05 85% = $110.00
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) **Fee:** $212.45 **Benefit:** 75% = $159.35
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70
49815	FOOT, triple arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.) **Fee:** $743.80 **Benefit:** 75% = $557.85
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) **Fee:** $808.40 **Benefit:** 75% = $606.30
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $508.15 **Benefit:** 75% = $381.15
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $877.70 **Benefit:** 75% = $658.30
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $635.20 **Benefit:** 75% = $476.40
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $1,096.90 **Benefit:** 75% = $822.70
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.) **Fee:** $508.15 **Benefit:** 75% = $381.15
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) **Fee:** $877.70 **Benefit:** 75% = $658.30
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45
49848	FOOT, correction of claw or hammer toe (Anaes.) **Fee:** $157.05 **Benefit:** 75% = $117.80 85% = $133.50
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) **Fee:** $203.15 **Benefit:** 75% = $152.40
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) **Fee:** $369.55 **Benefit:** 75% = $277.20

49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) **Fee:** $341.85 **Benefit:** 75% = $256.40
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.) **Fee:** $277.10 **Benefit:** 75% = $207.85
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.) **Fee:** $415.85 **Benefit:** 75% = $311.90
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.) **Fee:** $295.45 **Benefit:** 75% = $221.60
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) **Fee:** $55.45 **Benefit:** 75% = $41.60 85% = $47.15
	OTHER JOINTS
50100	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $323.45 **Benefit:** 75% = $242.60
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $306.50 **Benefit:** 75% = $229.90 85% = $260.55
50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $461.90 **Benefit:** 75% = $346.45
50112	CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $354.30 **Benefit:** 75% = $265.75
50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Group applies (Anaes.) **Fee:** $140.30 **Benefit:** 75% = $105.25 85% = $119.30
50118	SUBTALAR JOINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $424.90 **Benefit:** 75% = $318.70
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.) **Fee:** $831.55 **Benefit:** 75% = $623.70
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.) **Fee:** $689.40 **Benefit:** 75% = $517.05
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) **Fee:** $306.50 **Benefit:** 75% = $229.90
	MALIGNANT DISEASE
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) **Fee:** $184.70 **Benefit:** 75% = $138.55 85% = $157.00

50201	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, involving neurovascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.) **Fee:** $323.35 **Benefit:** 75% = $242.55
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) **Fee:** $406.55 **Benefit:** 75% = $304.95 85% = $345.60
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $600.50 **Benefit:** 75% = $450.40
50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) **Fee:** $739.20 **Benefit:** 75% = $554.40
50212	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.) (Assist.) **Fee:** $1,616.85 **Benefit:** 75% = $1,212.65
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.) **Fee:** $2,032.60 **Benefit:** 75% = $1,524.45
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint, with synovectomy if performed (Anaes.) (Assist.) **Fee:** $2,679.40 **Benefit:** 75% = $2,009.55
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.) **Fee:** $2,494.45 **Benefit:** 75% = $1,870.85
50224	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.) **Fee:** $2,771.70 **Benefit:** 75% = $2,078.80 85% = $2,698.00
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.) **Fee:** $3,233.65 **Benefit:** 75% = $2,425.25
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.) **Fee:** $1,663.00 **Benefit:** 75% = $1,247.25
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.) **Fee:** $2,125.00 **Benefit:** 75% = $1,593.75
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.) **Fee:** $1,663.00 **Benefit:** 75% = $1,247.25
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.) **Fee:** $1,108.60 **Benefit:** 75% = $831.45
	LIMB LENGTHENING AND DEFORMITY CORRECTION
50300	JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.) **Fee:** $1,136.10 **Benefit:** 75% = $852.10
50303	LIMB LENGTHENING, 5cm or less, by gradual distraction, with application of an external fixator or intra-medullary device, in the operating theatre of a hospital - payable only once per limb in any 12 month period (Anaes.) (Assist.) **Fee:** $1,551.15 **Benefit:** 75% = $1,163.40
50306	LIMB LENGTHENING , where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity, or where the lengthening is greater than 5cm (Anaes.) (Assist.) **Fee:** $2,421.90 **Benefit:** 75% = $1,816.45 85% = $2,348.20

50309	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.) **Fee:** $299.35 **Benefit:** 75% = $224.55
50312	ANKLE, synovectomy of, by arthroscopic or open means - not associated with any other arthroscopic procedure of the ankle (Anaes.) (Assist.) **Fee:** $687.05 **Benefit:** 75% = $515.30
50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.) **Fee:** $680.35 **Benefit:** 75% = $510.30
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.) **Fee:** $680.35 **Benefit:** 75% = $510.30
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.) **Fee:** $911.55 **Benefit:** 75% = $683.70
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.) **Fee:** $1,299.45 **Benefit:** 75% = $974.60
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.) **Fee:** $1,585.05 **Benefit:** 75% = $1,188.80
50330	TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital, not being a service to which item 50315, 50318, 50321, 50324 or 50327 applies (Anaes.) **Fee:** $224.45 **Benefit:** 75% = $168.35 85% = $190.80
50333	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.) **Fee:** $605.35 **Benefit:** 75% = $454.05
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.) **Fee:** $904.85 **Benefit:** 75% = $678.65
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.) **Fee:** $551.10 **Benefit:** 75% = $413.35
50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.) **Fee:** $639.45 **Benefit:** 75% = $479.60
50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.) **Fee:** $340.20 **Benefit:** 75% = $255.15
	HIP, KNEE AND LEG PROCEDURES
50348	KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.) **Fee:** $224.45 **Benefit:** 75% = $168.35 85% = $190.80
50349	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.) **Fee:** $314.20 **Benefit:** 75% = $235.65 85% = $267.10
50351	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.) **Fee:** $1,567.45 **Benefit:** 75% = $1,175.60 85% = $1,493.75
50352	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.) **Fee:** $55.45 **Benefit:** 75% = $41.60 85% = $47.15
50353	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.) **Fee:** $348.20 **Benefit:** 75% = $261.15
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.) **Fee:** $1,285.70 **Benefit:** 75% = $964.30 85% = $1,212.00

50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $551.10 **Benefit:** 75% = $413.35
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.) **Fee:** $639.45 **Benefit:** 75% = $479.60
50363	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.) **Fee:** $489.75 **Benefit:** 75% = $367.35
50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.) **Fee:** $857.15 **Benefit:** 75% = $642.90
50369	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.) **Fee:** $639.45 **Benefit:** 75% = $479.60
50372	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.) **Fee:** $1,122.45 **Benefit:** 75% = $841.85
50375	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.) **Fee:** $489.75 **Benefit:** 75% = $367.35
50378	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.) (Assist.) **Fee:** $857.15 **Benefit:** 75% = $642.90
50381	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.) (Assist.) **Fee:** $639.45 **Benefit:** 75% = $479.60
50384	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes.) (Assist.) **Fee:** $1,122.45 **Benefit:** 75% = $841.85
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.) **Fee:** $639.45 **Benefit:** 75% = $479.60
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital (Anaes.) **Fee:** $224.45 **Benefit:** 75% = $168.35 85% = $190.80
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) **Fee:** $829.85 **Benefit:** 75% = $622.40
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) **Fee:** $2,725.50 **Benefit:** 75% = $2,044.15
	SHOULDER, ARM AND FOREARM PROCEDURES
50396	HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.) **Fee:** $455.90 **Benefit:** 75% = $341.95
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) **Fee:** $904.85 **Benefit:** 75% = $678.65
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.) **Fee:** $415.05 **Benefit:** 75% = $311.30
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) **Fee:** $564.65 **Benefit:** 75% = $423.50

50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) **Fee:** $979.65 **Benefit:** 75% = $734.75
	AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES
50411	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) **Fee:** $1,285.70 **Benefit:** 75% = $964.30 85% = $1,212.00
50414	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.) **Fee:** $1,734.65 **Benefit:** 75% = $1,301.00 85% = $1,660.95
50417	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.) **Fee:** $1,285.70 **Benefit:** 75% = $964.30 85% = $1,212.00
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.) **Fee:** $1,061.20 **Benefit:** 75% = $795.90
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) **Fee:** $979.65 **Benefit:** 75% = $734.75 85% = $905.95
	TUMOROUS CONDITIONS
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) **Fee:** $455.90 **Benefit:** 75% = $341.95
	SINGLE EVEN MULTILEVEL SURGERY FOR CHILDREN WITH CEREBRAL PALSY
50450	**UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:** - 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 femoral torsion by rotational osteotomy of the femur. - Correction of tibial torsion by rotational osteotomy of the tibia. - Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $1,204.00 **Benefit:** 75% = $903.00
50451	**UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with hemiplegic cerebral palsy comprising three or more of the following:** (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 femoral torsion by rotational osteotomy of the femur. (d) Correction of tibial torsion by rotational osteotomy of the tibia. (e) Correction of joint instability by varus derotation osteotomy of the femur, subtalar arthrodesis, with synovectomy if performed, or os calcis lengthening. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $1,204.00 **Benefit:** 75% = $903.00
50455	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:** - 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. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $1,363.50 **Benefit:** 75% = $1,022.65

50456	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises:** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $1,363.50 **Benefit:** 75% = $1,022.65
50460	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.** - Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. - Correction of muscle imbalance by tendon transfer/transfers. - Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $2,035.75 **Benefit:** 75% = $1,526.85
50461	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $2,035.75 **Benefit:** 75% = $1,526.85
50465	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.** - 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.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $2,867.30 **Benefit:** 75% = $2,150.50
50466	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.** (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.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $2,867.30 **Benefit:** 75% = $2,150.50
50470	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.** - 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. - Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $3,636.45 **Benefit:** 75% = $2,727.35

50471	**BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.** (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. (e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $3,636.45 **Benefit:** 75% = $2,727.35
50475	**SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:** - Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. - Correction of muscle imbalance by tendon transfer/transfers. - Correction of flexion deformity at the knee by extension osteotomy of the distal femur including internal fixation. - Correction of patella alta and quadriceps insufficiency by patella tendon shortening/reconstruction. - Correction of tibial torsion by rotational osteotomy of the tibia with internal fixation. - Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $4,196.10 **Benefit:** 75% = $3,147.10
50476	**SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy for the correction of crouch gait including:** (a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening. (b) Correction of muscle imbalance by tendon transfer/transfers. (c) Correction of flexion deformity at the knee by extension osteotomy of the distal femur including 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 internal fixation. (f) Correction of foot instability by os calcis lengthening or subtalar fusion. Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $4,196.10 **Benefit:** 75% = $3,147.10
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
50500	RADIUS OR ULNA, distal end of, ***with open growth plate***, treatment of fracture of, by closed reduction (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $271.50 **Benefit:** 75% = $203.65 85% = $230.80
50504	RADIUS OR ULNA, distal end of, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $362.15 **Benefit:** 75% = $271.65 85% = $307.85
50508	RADIUS, distal end of, ***with open growth plate***, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $387.90 **Benefit:** 75% = $290.95 85% = $329.75
50512	RADIUS, distal end of, ***with open growth plate***, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $517.45 **Benefit:** 75% = $388.10
50516	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $349.20 **Benefit:** 75% = $261.90 85% = $296.85
50520	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $465.55 **Benefit:** 75% = $349.20

50524	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $400.90 **Benefit:** 75% = $300.70 85% = $340.80
50528	RADIUS OR ULNA, shaft of, ***with open growth plate***, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $646.70 **Benefit:** 75% = $485.05
50532	RADIUS AND ULNA, shafts of, ***with open growth plates***, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $562.70 **Benefit:** 75% = $422.05
50536	RADIUS AND ULNA, shafts of, ***with open growth plates***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $750.15 **Benefit:** 75% = $562.65
50540	OLECRANON, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $517.45 **Benefit:** 75% = $388.10
50544	RADIUS, ***with open growth plate***, treatment of fracture of head or neck of, by closed reduction of (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $258.70 **Benefit:** 75% = $194.05 85% = $219.90
50548	RADIUS, ***with open growth plate***, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $517.45 **Benefit:** 75% = $388.10
50552	HUMERUS, proximal, ***with open growth plate***, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $446.25 **Benefit:** 75% = $334.70 85% = $379.35
50556	HUMERUS, proximal, ***with open growth plate***, treatment of fracture of, by open reduction (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $594.90 **Benefit:** 75% = $446.20
50560	HUMERUS, shaft of, ***with open growth plate***, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $465.55 **Benefit:** 75% = $349.20
50564	HUMERUS, shaft of, ***with open growth plate***, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $620.85 **Benefit:** 75% = $465.65
50568	HUMERUS, ***with open growth plate***, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $543.30 **Benefit:** 75% = $407.50 85% = $469.60
50572	HUMERUS, ***with open growth plate***, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $724.35 **Benefit:** 75% = $543.30
50576	FEMUR, ***with open growth plate***, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $594.90 **Benefit:** 75% = $446.20 85% = $521.20

50580	TIBIA, ***with open growth plate***, plateau or condyles, medial or lateral, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $620.85 **Benefit:** 75% = $465.65
50584	TIBIA, distal, ***with open growth plate,*** treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $594.90 **Benefit:** 75% = $446.20
50588	TIBIA AND FIBULA, ***with open growth plates***, treatment of fracture of, by internal fixation (Anaes.) (Assist.) *(See para T8.122 and T8.123 of explanatory notes to this Category)* **Fee:** $775.95 **Benefit:** 75% = $582.00
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
50600	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $426.60 **Benefit:** 75% = $319.95 85% = $362.65
50604	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $1,810.65 **Benefit:** 75% = $1,358.00
50608	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $3,363.05 **Benefit:** 75% = $2,522.30
50612	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $4,783.60 **Benefit:** 75% = $3,587.70
50616	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $607.80 **Benefit:** 75% = $455.85
50620	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $3,363.05 **Benefit:** 75% = $2,522.30
50624	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $3,363.05 **Benefit:** 75% = $2,522.30
50628	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $4,154.25 **Benefit:** 75% = $3,115.70
50632	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $3,492.30 **Benefit:** 75% = $2,619.25
50636	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the spinal cord with vertebral resection and instrumentation in the presence of spinal cord involvement, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $3,880.35 **Benefit:** 75% = $2,910.30

50640	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach, not being a service to which item 48642 to 48675 applies (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $2,145.05 **Benefit:** 75% = $1,608.80
50644	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of scoliosis or kyphosis or both (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $2,069.65 **Benefit:** 75% = $1,552.25
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENTS
50650	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrography of the hip under anaesthesia (Anaes.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $407.00 **Benefit:** 75% = $305.25 85% = $345.95
50654	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica, including examination of the hip (Anaes.) (Assist.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $487.40 **Benefit:** 75% = $365.55
50658	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip under anaesthesia (Anaes.) *(See para T8.122 of explanatory notes to this Category)* **Fee:** $194.05 **Benefit:** 75% = $145.55 85% = $164.95
	SUBGROUP 16 - RADIOFREQUENCY ABLATION
50950	NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by percutaneous radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50952 applies (Anaes.) **Fee:** $801.85 **Benefit:** 75% = $601.40 85% = $728.15
50952	NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by open or laparoscopic radiofrequency ablation, where a multi-disciplinary team has assessed that percutaneous radiofrequency ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: - percutaneous access cannot be achieved; - vital organs/tissues are at risk of damage from the percutaneous RFA procedure; or - resection of one part of the liver is possible however there is at least one primary liver tumour in a non-resectable region of the liver which is suitable for radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50950 applies (Anaes.) *(See para T8.124 of explanatory notes to this Category)* **Fee:** $801.85 **Benefit:** 75% = $601.40 85% = $728.15

	GROUP T9 - ASSISTANCE AT OPERATIONS
51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed $547.90 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $547.90 *(See para T9.1 and T9.2 of explanatory notes to this Category)* **Fee:** $84.70 **Benefit:** 75% = $63.55 85% = $72.00
51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $547.90 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $547.90 *(See para T9.1 and T9.3 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations
51306	Assistance at a delivery involving Caesarean section *(See para T9.1 of explanatory notes to this Category)* **Fee:** $122.35 **Benefit:** 75% = $91.80 85% = $104.00
51309	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section *(See para T9.1 and T9.4 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 *(See para T9.1 of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the procedure or combination of procedures
51315	Assistance at cataract and intraocular lens surgery covered by item 42698,42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42746, 42749, 42752, 42776 or 42779 *(See para T9.1 of explanatory notes to this Category)* **Fee:** $267.30 **Benefit:** 75% = $200.50 85% = $227.25
51318	Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage *(See para T9.1 and T9.5 of explanatory notes to this Category)* **Fee:** $176.40 **Benefit:** 75% = $132.30 85% = $149.95

INDEX

A

Abbe flap, reconstruction of cleft lip 45701
reconstruction of lip or eyelid 45671
Abdomen, burst, repair of 30403
closure of and repair of musculoaponeurotic layer 45570
closure of, in conjunction with free tissue transfer or breast reconstruction 45569
abdominal aortic aneurysm, endovascular repair 33116,33119
Abdominal apron, wedge excision 30165,30168,30171
aortic aneurysm, endovascular repair of 33116,33119
musculature transfer to greater trochanter 50387
paracentesis 30406
viscera, operations involving laparotomy 30387
wall vitello intestinal remnant, excision of 43942
Abdomino-perineal resection, rectum and anus 32039,32042,32045 32046
Abdomino-vaginal op for stress incontinence 35602,35605
Abdominoplasty, Pitanguy type 30177
Abortion, threatened, treatment of 16505
Abrasive therapy 45021,45024
Abscess, anal, drainage of 32174,32175
appendiceal, laparotomy for drainage 30394
Bartholin's, incision of 35520
breast, exploration and drainage 31551
deep, percutaneous drainage 30224
drainage tube, exchange of 30225
extradural, laminectomy for 40309
intra-orbital, drainage of 42572
intracranial, excision of 39903
ischio-rectal, drainage of 32174,32175
laparotomy for drainage of 30394
large, incision and drainage, with GA 30223
liver, open abdominal drainage of 30431
middle ear, operation for 41626
pancreatic, laparotomy, external drainage 30575
pelvic, laparotomy for drainage of 30394
peritonsillar, incision of 41807
prostate, drainage of 37212,37221
retroperitoneal, drainage of 30402
small, incision, drainage, without GA 30219
subperiosteal 43500,43503,43506 43509,43512,43515,43518,43521,43524
subphrenic, laparotomy for drainage 30394
Accessory bone, osteotomy or osteectomy of 48400
Acetabular dysplasia, pelvis, bone graft/shelf procedure 50393
Acetabulum, treatment of fracture of 47492,47495,47498 47501,47504,47507,47510
Achilles' tendon, operation for lengthening 49727
tendon, repair of 49718,49721,49724
Acoustic neuroma, removal of 41575,41576,41578 41579
Adductors to ischium transfer 50387
Adenoids and tonsils, removal of 41788,41789,41792 41793
removal of 41800,41801
Adhesions, division of, via laparoscope 31450,31452,35637
division of, with laparoscopy 30393
division of, with laparotomy 30376,30378,30379
liver, destruction of by cryotherapy 30419
nasal, division of 41683
pharyngeal, division of 41758
Administration of 16018
Adrenal gland, excision of 36500
gland tumour, excision of 30324
hyperplasia, congenital, vaginoplasty for 37851
Alcohol, injection of trigeminal nerve/s 39100
retrobulbar injection of 42824
Alimentary continuity, primary restoration 41843
obstruction, neonatal, laparotomy for 43825
Alopecia, hair transplantation for 45560
Alveolar ridge augmentation 45841,45843
Amnio-infusion 16621
Amniocentesis, diagnostic 16600
therapeutic 16618
Amputation, limb, digit etc. 44325,44328,44331 44334,44338,44342,44346,44350,44354,44358,44359 44361,44364,44367,44370,44373,44376
stump, reamputation of 44376
stump, revision of 46483
Anaesthetic, Relative Value Guide 20100,20102,20104 20120,20124,20140,20142-20148,20160,20162,20164 20170,20172,20174,20176,20190,20192,20210,20212 20214,20216,20220,20222,20225,20230,20300,20305 20320,20321,20330,20350,20352,20355,20400-20406 20410,20420,20440,20450,20452,20470,20472,20474 20475,20500,20520,20522,20524,20526,20528,20540 20542,20546,20548,20560,20600,20604,20620,20622 20630,20632,20634,20670,20680,20690,20700 20702-20706,20730,20740,20745,20750,20752,20754 20756,20770,20790-20794,20798-20800,20802-20806 20810,20815,20820,20830,20832,20840-20842 20844-20848,20850,20855,20860,20862-20864 20866-20868,20880,20882,20884,20886,20900,20902 20904-20906,20910-20912,20914,20916,20920,20924 20926,20928,20930,20932,20934,20936,20938,20940 20942-20944,20946,20948,20950,20952-20954,20956 20958,20960,21100,21110,21112,21114,21116,21120 21130,21140,21150,21155,21160,21170,21195,21199 21200,21202,21210,21212,21214,21216,21220,21230 21232,21234,21260,21270,21272,21274,21275,21280 21300,21321,21340,21360,21380,21382,21390,21392 21400,21402-21404,21420,21430,21432,21440,21445 21460-21462,21464,21472,21474,21480,21482,21484 21486,21490,21500,21502,21520,21522,21530,21532 21535,21600,21610,21620,21622,21630,21632,21634 21636,21638,21650,21652,21654,21656,21670,21680 21682,21685,21700,21710,21712,21714,21716,21730 21732,21740,21756,21760,21770,21772,21780,21785 21790,21800,21810,21820,21830,21832,21834,21840 21842,21850,21860,21865,21870,21872,21878-21887 21900,21906,21908,21910,21912,21914-21916,21918 21922,21925-21927,21930,21935,21936,21939 21941-21943,21945,21949,21952,21955,21959,21962 21965,21969,21970,21973,21976,21980,21981,21990 21992,21997,22001,22002,22007,22008,22012,22014 22015,22018,22020,22025,22031,22036,22040,22045 22050,22051,22055,22060,22065,22070,22075,22900 22905,23010,23021-23023,23031-23033,23041-23043 23051-23053,23061-23063,23071-23073,23081-23083 23091,23101,23111-23119,23121,23170,23180,23190 23200,23210,23220,23230,23240,23250,23260,23270 23280,23290,23300,23310,23320,23330,23340,23350 23360,23370,23380,23390,23400,23410,23420,23430 23440,23450,23460,23470,23480,23490,23500,23510 23520,23530,23540,23550,23560,23570,23580,23590 23600,23610,23620,23630,23640,23650,23660,23670 23680,23690,23700,23710,23720,23730,23740,23750 23760,23770,23780,23790,23800,23810,23820,23830 23840,23850,23860,23870,23880,23890,23900,23910 23920,23930,23940,23950,23960,23970,23980,23990 24100-24136,25000,25005,25010,25015,25020,25025 25030,25050,25200,25205
abdomen, lower 20800,20802-20806,20810 20815,20820,20830,20832,20840-20842,20844-20848 20850,20855,20860,20862-20864,20866-20868,20880 20882,20884
abdomen, upper 20700,20702-20706,20730

20740,20745,20750,20752,20754,20756,20770
20790-20794,20798,20799
anaesthesia in connection with burns 21878-21887
anaesthesia in connection with dental services 22900,22905
anaesthesia in connection with radiological diagnostic
or therapeutic procedures 21900,21906,21908
21910,21912,21914-21916,21918,21922,21925-21927
21930,21935,21936,21939,21941-21943,21945,21949
21952,21955,21959,21962,21965,21969,21970,21973
21976,21980
anaesthesia modifiers 25000,25005,25010
25015,25020,25025,25030
anaesthesia time 23010,23021-23023,23031-23033
23041-23043,23051-23053,23061-23063,23071-23073
23081-23083,23091,23101,23111-23119,23121,23170
23180,23190,23200,23210,23220,23230,23240,23250
23260,23270,23280,23290,23300,23310,23320,23330
23340,23350,23360,23370,23380,23390,23400,23410
23420,23430,23440,23450,23460,23470,23480,23490
23500,23510,23520,23530,23540,23550,23560,23570
23580,23590,23600,23610,23620,23630,23640,23650
23660,23670,23680,23690,23700,23710,23720,23730
23740,23750,23760,23770,23780,23790,23800,23810
23820,23830,23840,23850,23860,23870,23880,23890
23900,23910,23920,23930,23940,23950,23960,23970
23980,23990,24100-24136
arm, upper (and elbow) 21700,21710,21712
21714,21716,21730,21732,21740,21756,21760,21770
21772,21780,21785,21790
assistance at anaesthesia 25200,25205
assistance time 23010,23021-23023,23031-23033
23041-23043,23051-23053,23061-23063,23071-23073
23081-23083,23091,23101,23111-23119,23121,23170
23180,23190,23200,23210,23220,23230,23240,23250
23260,23270,23280,23290,23300,23310,23320,23330
23340,23350,23360,23370,23380,23390,23400,23410
23420,23430,23440,23450,23460,23470,23480,23490
23500,23510,23520,23530,23540,23550,23560,23570
23580,23590,23600,23610,23620,23630,23640,23650
23660,23670,23680,23690,23700,23710,23720,23730
23740,23750,23760,23770,23780,23790,23800,23810
23820,23830,23840,23850,23860,23870,23880,23890
23900,23910,23920,23930,23940,23950,23960,23970
23980,23990,24100-24136
assistance, modifiers 25000,25005,25010
25015,25020,25025,25030
forearm, wrist & hand 21800,21810,21820
21830,21832,21834,21840,21842,21850,21860,21865
21870,21872
head 20100,20102,20104
20120,20124,20140,20142-20148,20160,20162,20164
20170,20172,20174,20176,20190,20192,20210,20212
20214,20216,20220,20222,20225
intrathoracic 20500,20520,20522
20524,20526,20528,20540,20542,20546,20548,20560
knee & popliteal area 21300,21321,21340
21360,21380,21382,21390,21392,21400,21402-21404
21420,21430,21432,21440
leg, lower (below knee) 21460-21462,21464,21472
21474,21480,21482,21484,21486,21490,21500,21502
21520,21522,21530,21532
leg,upper (except knee) 21195,21199,21200
21202,21210,21212,21214,21216,21220,21230,21232
21234,21260,21270,21272,21274,21275,21280
neck 20300,20305,20320
20321,20330,20350,20352
pelvis (except hip) 21100,21110,21112
21114,21116,21120,21130,21140,21150,21155,21160
21170
perfusion, modifiers 25000,25005,25010
25015,25020,25050
perfusion, time 23010,23021-23023,23031-23033
23041-23043,23051-23053,23061-23063,23071-23073
23081-23083,23091,23101,23111-23119,23121,23170
23180,23190,23200,23210,23220,23230,23240,23250
23260,23270,23280,23290,23300,23310,23320,23330
23340,23350,23360,23370,23380,23390,23400,23410
23420,23430,23440,23450,23460,23470,23480,23490
23500,23510,23520,23530,23540,23550,23560,23570
23580,23590,23600,23610,23620,23630,23640,23650
23660,23670,23680,23690,23700,23710,23720,23730
23740,23750,23760,23770,23780,23790,23800,23810
23820,23830,23840,23850,23860,23870,23880,23890
23900,23910,23920,23930,23940,23950,23960,23970
23980,23990,24100-24136
perfusion, whole body, cardiac bypass 22060
perineum 20900,20902,20904-20906
20910-20912,20914,20916,20920,20924,20926,20928
20930,20932,20934,20936,20938,20940,20942-20944
20946,20948,20950,20952-20954,20956,20958,20960
shoulder & axilla 21600,21610,21620
21622,21630,21632,21634,21636,21638,21650,21652
21654,21656,21670,21680,21682
spine & spinal cord 20600,20604,20620
20622,20630,20632,20634,20670,20680,20690
thorax 20400-20406,20410,20420
20440,20450,20452,20470,20472,20474
Anal canal, laser therapy (restriction) 35539,35542,35545
fissure, operation for, including excision 32150
fistula, excision/repair 32156,32159,32162
32165
fistula, readjustment of Seton 32166
graciloplasty 32203
graciloplasty, insertion of stimulator & electrode 32209
incontinence, Parks' procedure 32126
skin tags or polyps, excision of 32142,32145
sphincter, direct repair of 32129
sphincterotomy, independent, Hirschsprung's 43999
stricture, anoplasty for 32123
warts, removal under GA or nerve block 32177,32180
Anastomosis, aorta, congenital heart disease 38706,38709
arterial/venous, independent 32766
arterial/venous, with other operation 32769
arteriovenous, upper or lower limb 34503,34509
facio-hypoglossal/accessory nerve 39503
ileo-rectal, with total colectomy 32012
intrathoracic, congenital heart disease 38727,38730
microvascular, in plastic surgery 45502
oesophageal atresia, neonatal 43855
saphenous vein, for femoral vein bypass 34809
vena cava, for congenital heart disease 38721,38724
Aneurysm, cerebrovascular, clipping/reinforcement 39800
intracranial proximal artery clipping 39806
intracranial, ligation cervical vessels 39812
left ventricular, plication of 38506
left ventricular, resection 38507,38508
major artery, replacement/repair 33050,33055,33070
33075,33080,33100,33103,33109,33112,33115,33116
33118,33119,33121,33124,33127,33130,33133,33136
33139,33142,33145,33148,33151,33154,33157,33160
33163,33166,33169,33172,33175,33178,33181
Angiofibroma, face/neck, removal by laser excision 30190
nasopharyngeal, removal 41767
angiography, selected coronary 38215,38218,38220
38222,38225,38228,38231,38234,38237,38240,38241
38243,38246
Angioma, cauterisation/injection into 45027
excision of 45030,45033,45035
45036
Angioplasty, peripheral laser 35315
transluminal balloon 35300,35303
Angioscopy 35324,35327

Ankle, achilles tendon, operation for lengthening 49727
achilles tendon, repair of 49718,49721,49724
and foot, tibialis tendon transfer 50339,50342
arthrodesis of 49712
arthroscopic surgery of 49703
arthroscopy of, diagnostic 49700
arthrotomy of 49706
dislocation, treatment of 47063,47066
fracture, treatment of 47594,47597,47600
47603
gastrocnemius aponeurosis, operation for lengthening 49728
ligamentous stabilisation of 49709
major tendon repair 49718
revision arthroplasty 49716,49717
synovectomy of 50312
tibialis tendon transfer 50339,50342
total joint replacement 49715
Annuloplasty, heart valve 38475,38477,38478
Anophthalmic orbit, insertion cartilage/implant 42518
orbit, placement of motility integrating peg 42518
orbit, removal of implant from socket 42518
socket, treatment as secondary procedure 42521
Anoplasty for anal stricture 32123
Anorectal carcinoma, excision of 32105
application of formalin 32212
examination, under GA 32171
malformation, neonatal, laparotomy and colostomy 43822
malformation, paediatric, operations 43960,43963,43966
Anorectoplasty of anorectal malformation 43963,43966
Antenatal cardiotocography (restriction) 16514
care, independent of confinement 16500
service provided by a midwife, nurse or registered
Aboriginal Health Worker 16400
Antepartum haemorrhage, treatment of 16509
Anterior chamber, irrigation of blood from 42743
resection of rectum 32024,32025
section of corpus callosum for epilepsy 40700
synechiae, division of 42761
vaginal repair 35570-35573,35577,35578
Antireflux operations 30527,30529,30530
operation by fundoplasty 31464,31466
Antrectomy and/or vagotomy 30497,30503
Antrobuccal fistula operation 41722
Antroscopy of temporomandibular joint 45855,45857
Antrostomy, radical 41710,41713
Antrum, drainage of, through tooth socket 41719
intranasal, operation on 41716
maxillary, lavage of 41704
maxillary, proof puncture, lavage 41698,41701
removal of foreign body from 41716
Anus, dilatation of (Lord's procedure) 32153
Aorta, anastomosis, congenital heart disease 38706,38709
thoracic, management of rupture/dissection 38572
thoracic, repair/replacement procedures 38550,38553,38556
38559,38562,38565,38568,38571
Aortic bypass 32708,32710,32711
endarterectomy 33509
interruption, repair of 38712
valve leaflet/s, decalcification of 38483
Aorto-duodenal fistula, repair of 34160,34163,34166
Aorto-femoral endarterectomy 33515
Aorto-iliac endarterectomy 33512
Aortopexy for tracheomalacia 43909
Appendiceal abscess, laparotomy for drainage 30394
Appendicectomy 30571,30572,30574
Appendix, ruptured, laparotomy for drainage 30394
Arachnoidal cyst, craniotomy for 39718
Arch Bars, to maxilla or mandible, removal of 45823
Areola, reconstruction of 45545,45546
Arm, amputation or disarticulation of 44328
Arnold Chiari malformation, decompression of 40106
Arrhythmia ablation 38287,38290,38293
surgery 38390,38393,38512
38515,38518
Arterial anastomosis, not otherwise covered 32766,32769
atherectomy, peripheral 35312
cannulation for infusion chemotherapy, open 34524
catheterisation, peripheral 35317,35319-35321
line for blood pressure monitoring 13876
puncture and blood collection, diagnostic 13839
Arteries, major, access as part of re-operation 35202
Arteriography, operative 35200
Arteriography, preparation for 38215
Arteriography, preparation for 38218
Arteriovenous access device, insertion of 34512
access device, prosthetic, correction of 34518
access device, thrombectomy of 34515
anastomosis of upper or lower limb 34503,34509
fistula extremity, surgically created, closure 34130
fistula, dissection and ligation/repair 34112,34115,34118
34121,34124,34127
fistula, ligation of cervical vessel/s 39812
fistula, stenosis of, correction of 34518
malformation, excision of 45039,45042,45045
malformation, intracranial artery clipping of 39806
malformation, intracranial, excision of 39803
malformation, laminectomy, radical excision of 40318
shunt, declotting of 13106
shunt, external, insertion/removal 34500,34506
Artery, anastomosis of, microvascular 45502
bypass grafting, occlusive arterial disease 32700,32703,32708
32710-32712,32715,32718,32721,32724,32730,32733
32736,32739,32742,32745,32748,32751,32754,32757
32760,32763
coeliac, decompression of 34142
coronary, bypass operations 38497,38498,38500
38501,38503,38504
embolectomy of 33800,33803,33806
endarterectomy of 33500,33506,33509
33512,33515,33518,33521,33524,33527,33530,33533
33536,33539,33542
ethmoidal, transorbital ligation of 41725
great, ligation/exploration, other 34103
harvesting for coronary bypass 38496
ligation/exploration not otherwise covered 34106
major, of neck, ligation/exploration, other 34100
major, repair of wound of 33815,33818,33821
33824,33827,33830,33833,33836,33839
maxillary, transantral ligation of 41707
neck, reoperation for bleeding/thrombosis 33842
patch grafting to 33545,33548
popliteal, exploration for popliteal entrapment 34145
temporal, biopsy of 34109
thrombectomy of 33803,33806
Arthrectomy, hip 49309,49312
rotational,coronary artery 38309,38312,38315
38318
Arthrocentesis. with irrigation of temporomandibular
joint 45865
Arthrodesis, ankle 49712
elbow 49106
finger/hand 46300,46303
foot 49815,49845
hip 49306
joint, other 50109
knee 49509,49512,49545
sacro-iliac joint 49300
shoulder 48939,48942
subtalar joint 50118
wrist 49200,49203
Arthroplasty, ankle 49715
carpal bone 46324,46325

finger/hand 46306,46307,46309
46312,46315,46318,46321
foot 49839,49842
hip 49309,49312,49315
49318,49319,49321,49324,49327,49330,49333,49346
joint, other 50127
knee 49518,49519,49521
49524,49527,49530,49533,49534
shoulder 48915,48918,48921
48924
temporomandibular joint 45758
wrist 49209
Arthroscopy, ankle 49700,49703
elbow 49118,49121
hip 49360,49363,49366
joint, other 50100,50102
knee 49557-49564,49566
shoulder 48945,48948,48951
48954,48957,48960
wrist 49218,49221,49224
49227
Arthrotomy, ankle 49706
elbow 49100
finger/hand 46327,46330
hip 49303
joint, other 50103
knee 49500
shoulder 48912
wrist 49212
Artificial erection device, insertion of 37426,37429
erection device, revision or removal of 37432
insemination services 13203,13209,13221
lens, insertion of 42701
lens, removal of 42704
lens, removal, replacement different lens 42707
lens, repositioning of, open operation 42704
urinary sphincter, insertion 37381,37384,37387
urinary sphincter, revision/removal 37390
Arytenoidectomy with microlaryngoscopy 41867
Aspiration biopsy, bone marrow 30087
biopsy, deep organ, imaging guided 30094
of bladder, needle 37041
of haematoma 30216
of thoracic cavity 38800,38803
one or more jaw cysts 45799
Assistance at operations 51300,51303,51306
51309,51312,51315,51318
Assisted reproductive technologies 13200,13203,13206
13209,13212,13215,13218,13221
Atherectomy, peripheral arterial 35312
Atresia, choanal, repair/correction 45645,45646
external auditory canal, reconstruction 45662
Atrial chamber/s, operations for arrhythmia 38512,38515
septal defect closure, surgical 38742
septal defect closure, transcatheter approach 38272
septectomy 38739
Attendance, acupuncture
antenatal 16500
intensive care unit (specialist) 13870,13873
Atticotomy 41533,41536
Auditory canal, external 41524
- reconstruction, congenital atresia 45662
- removal of foreign body, incision 41503
canal external, blind sac closure 41564
canal stenosis, correction of, with meatoplasty 41521
meatus, external, removal of exostoses in 41518
meatus, internal, exploration 41599
Augmentation mammaplasty 45524,45527,45528
Aural polyp, removal of 41506
Autoconjunctival transplant 42641
Avulsion, penis, repair of 37411
Axilla, lymph glands, excision of 30332
lymph nodes, excision of 30335,30336
Axillary hyperhidrosis, excision for 30180,30183
to femoral bypass grafting 32715
vessel, ligation/exploration, other 34103
Axillofemoral graft, infected, excision of 34172

B

Baker's cyst, excision of 30114
Balloon catheter, right heart, insertion of 13818
intubation, gastro-oesophageal 13506
valvuloplasty or septostomy 38270
Bartholin's abscess, incision of 35520
cyst or gland, marsupialisation of 35516,35517
cyst, excision of 35512,35513
Barton's fracture of radius, treatment of 47369,47372,47375
Basal cell carcinoma, removal of31255-31258,31260-31263,31265-31268
31270-31273,31275-31278,31280-31283,31285-31288
31290-31293,31295
in oral & maxillofacial, complicated, removal 45811,45813
in oral & maxillofacial, uncomplicated, removal of45801,45803,45805
45807,45809
Bat ear or similar deformity, correction of 45659
Bicornuate uterus, plastic reconstruction for 35680
Bile duct, common, radical resection 30461,30463,30464
duct, common, repair of 30472
duct, endoscopic stenting of 30491
Biliary atresia, paediatric, portoenterostomy for 43978
bypass 30460,30466,30467
dilatation, endoscopic 30494
dilatation, percutaneous 30495
drainage tube exchange, imaging guided 30451
manometry 30493
stenting, percutaneous 30492
stricture, repair of 30469
Biopsy, aggressive bone/deep tissue tumour 50200,50201
biopsy, using ABBI 31539,31545
bone marrow 30081,30084,30087
breast 31530,31533,31548
cervix, cone 35617,35618
cervix, punch 35608
conjunctiva 42676
drill, lymph gland, deep tissue/organ 30078
endometrial, for suspected malignancy 35620
laparoscopic 30391
liver 30409,30411
lung, percutaneous needle 38812
lymph gland, muscle, other deep tissue/organ 30074,30075
lymph node of neck 31420
myocardial, by cardiac catherterisation 38275
percutaneous aspiration, deep organ 30094
pleura 30090
prostate 37212,37215,37218
punch, of synovial membrane 30087
rectum, full thickness 32096
renal (closed) 36561
scalene node 30096
sentinel lymph node, for breast cancer 30299,30300,30302
30303
skin or mucous membrane 30071
vertebra, needle 30093
Bladder, aspiration of, by needle 37041
biopsy of, with cystoscopy 36836
catheterisation of 36800
cystostomy or cystotomy 37008
diverticulum of, excision or obliteration 37020
ectopic, 'turning-in' operation 37842
enlargement of, using intestine 37047
excision of 37000,37014
exstrophy closure 37050

exstrophy of, repair of 37842
neck reconstruction, prostatectomy 37210,37211
neck resection, endoscopic 36854
repair of rupture 37004
stress incontinence, sling procedure 37042
stress incontinence, Stamey or similar 37043
stress incontinence, suprapubic procedure 37044
transection, with re-anastomosis to trigone 37053
tumour/s, diathermy/resection 36840,36845
tumour/s, laser destruction with cystoscopy 36840
Blood, administration of 13703,13706
arterial, collection for pathology 13839,13842
collection of, for transfusion 13709
collection of, in infants, for pathology 13312
peripheral, invitro processing, cryopreservation 13760
pressure monitoring, indwelling catheter (ICU only) 13876
retrograde admin for cardioplegia 38588
sampling, fetal 16606
transfusion 13703,13706
transfusion, fetal 16609,16612,16615
transfusion, paediatric/neonatal 13306,13309
Bone, cysts, injection into or aspiration of 47900
bone conduction hearing system 41603,41604
flap, infected, craniectomy for 39906
graft to femur 48200,48203
graft to humerus 48212,48215
graft to other bones 48239
graft to phalanx or metacarpal 46402,46405
graft to radius and ulna 48221
graft to radius or ulna 48218,48224,48227
graft to scaphoid 48230,48233,48236
graft to spine 48642,48645,48648
48651
graft to tibia 48206,48209
graft, harvesting of 47726,47729,47732
graft, with internal fixation 48242
growth stimulator 45821
lesion/s, removal, diaphyseal aclasia 50426
marrow, administration of 13706
marrow, aspiration biopsy of 30087
marrow, harvesting of for transplantation 13700
marrow, in vitro processing/cryopreservation 13760
tumour, benign, resection of 50230
tumour, innocent, excision of 30241
tumour, malignant, operations for 50200,50201,50203
50206,50209,50212,50215,50218,50221,50224,50227
50230,50233,50236,50239
Botulinum toxin, injection for 18350-18352,18354,18356
18358,18360,18362,18364,18366,18368,18370-18373
blepharospasm 18370-18373
cervical dystonia (spasmodic torticollis) 18352
dynamic equinovalgous 18358
dynamic equinovarous 18356
dynamic equinus foot deformity 18354
foot deformities due to spasticity 18354,18356,18358
hemifacial spasm 18350,18351
Boutonniere deformity, reconstruction of 46444,46447
Bowel, colectomy, total 32009,32012,32015
32018,32021
hemicolectomy 32000,32003,32006
ileostomy closure/reservoir 32060,32063,32066
32069
large, resection of 32000,32003
large, subtotal colectomy 32004,32005
perineal proctectomy 32047
rectosigmoidectomy (Hartmann's op) 32030
rectum and anus, resection 32039,32042,32045
32046
rectum, resection of 32024-32026,32028
resection for enterocolitis stricture, neonatal 43834
resection for jejunal atresia, neonatal 43810
restoration following Hartmann's op 32029,32033
ruptured, repair 30375
small, intubation 30487,30488
small, resection of 30565,30566
small, strictureplasty 30564
Brachial plexus, exploration of 39333
vessel, ligation/exploration, other 34106
Brachycephaly, cranial vault reconstruction for 45785
Brachytherapy planning 15536
For prostate cancer 15338,15513,15539
37220
Brain stem evoked response audiometry
stem tumour, craniotomy for removal 39709
Branchial cyst, removal of 30286
fistula, removal of 30289
Breast, biopsy, fine needle, imaging guided 31533
abnormality detected by mammography 31506
benign lesion 31500,31503
biopsy of solid tumour, vacuum-assisted, image guided 31530
central ducts, excision for benign condition 31557
core biopsy of solid tumour or tissue 31548
exploration/drainage, operating theatre 31551
lesion, pre-op localisation, for ABBI 31542
lesion, pre-op localisation, imaging guided 31536
malignant tumour 31509,31512
mammaplasty 45524,45527,45528
microdochotomy 31554
nipple, accessory, excision of 31566
prosthesis operations 45548,45551-45554
pstosis, correction of (unilateral) 45556,45557
ptosis, correction of (bilateral) 45558
reconstruction 45530,45533,45536
45539,45542
silicone prosthesis, removal of 45555
tissue, accessory, excision of 31560
tubuerous, tubular or constricted, correction of 45559
tumour site, re-excision 31515
Broad ligament cyst/tumour, excision/removal 35712,35713,35716
35717
Brodie's abscess, operation for 43515
Bronchial tree, intrathoracic operation on, other 38456
Bronchoscopy, as an independent procedure 41889
with biopsy or other procedure 41892
with dilatation of tracheal stricture 41904
with transbronchial lung biopsy 41898
Bronchus, dilatation of stricture and stent insertion 41905
operations on 41889,41892,41895
removal of foreign body in 41895
Broviac catheter, insertion of, for chemotherapy 34527,34528
catheter, removal of 34530
Bubonocele operation 30612,30614
Bunion, excision of 47933
Burch colposuspension 37044
Burns, dressing of (not involving grafting) 30003,30006,30009
30010,30013,30014
excision of under GA (not involving grafting) 30017,30020
free grafting 45406,45409,45412
45415,45418,45439,45442,45445,45448,45451
45460-45462,45464-45466,45468,45469,45471,45472
45474,45475,45477,45478,45480,45481,45483-45494
scars, excision of 45519
Burr-hole craniotomy, intracranial haemorrhage 39600
placement of intracranial electrodes 40709
single, preparatory to ventricular puncture 39012
Bursa, incision of
large, excision of 30110,30111
semimembranosus, excision of 30114
small, excision of 30106,30107
Burst abdomen, repair of 30403
Bypass, extracranial to intracranial 39818
graft, infected, of extremities, excision of 34175

graft, infected, of neck, excision of 34157
graft, infected, of trunk, excision of 34169
grafting for aneurysm 33050,33055
grafting, arterial, for occlusive arterial disease32700,32703,32708
32710-32712,32715,32718,32721,32724,32730,32733
32736,32739,32742,32745,32748,32751,32754,32757
32760,32763
grafting, cross leg, saphenous to iliac or femoral vein 34806

C

Caecostomy, 30375
closure of 30562
Caesarean section 16520,16522
Calcaneal spur, of foot, excision of 49818
Calcanean bursa, excision of 30110,30111
Calcaneum fracture, treatment of 47606,47609,47612
47615,47618
Calculus, biliary, extraction of 30454,30455,30457
30458
biliary/renal tract, extraction of 30450
bladder, removal of 36863
kidney, removal of 36540,36543
renal, extraction of 36627,36630,36633
36636,36639,36642,36645,36648
staghorn, nephrolithotomy and/or pyelolithotomy 36543
sublingual/salivary gland duct, removal of 30265,30266
ureter, removal of 36549
ureteric, endoscopic removal/manipulation 36857
Caldwell-Luc operation 41710
Calf, decompression fasciotomy of 47975,47978,47981
Cancer of skin/mucous membrane, removal 30196,30197,30202
30203,30205
Cannulae, membrane oxygenation 38627
bypass 38627
ventricular assist 38627
Cannulation, arterial, for infusion chemotherapy 34524
central vein 13318,13815
central vein, subcutaneous tunnel 34527
coronary sinus, for admin of blood or crystalloid 38588
for cardiopulmonary bypass 38600,38603
for retrograde cerebral perfusion 38577
intra-abdominal vessel, for chemotherapy 34521
peripheral arterial 35317,35319-35321
peripheral venous 35317,35319,35320
pulmonary artery 13818
umbilical artery 13303
umbilical/scalp vein in neonate 13300
Canthoplasty 42590
Capsule, posterior, needling of 42737
Capsulectomy 42719,42722,42731
of finger joints 46336
Capsulotomy, laser 42788,42789
other than laser 42734
Carbon dioxide laser resurfacing, face or neck 45025,45026
Carbuncle, incision and drainage, with GA 30223
Cardiac by-pass, whole body perfusion 22060
catheterisation 38200,38203,38206
38209,38212,38213,38215,38218,38220,38222
catheterisation - for myocardial biopsy 38275
deep hypothermic circulatory arrest 22075
electrophysiological studies 38209,38212,38213
operation (intrathoracic), other 38456
pacemaker, insertion/replacement 38353
resynchronisation therapy 38365,38368,38371
38654
rhythm, restoration, electrical stimulation 13400
surgery, for congenital heart disease 38700,38703,38706
38709,38712,38715,38718,38721,38724,38727,38730
38733,38736,38739,38742,38745,38748,38751,38754
38757,38760,38763,38766
surgery, re-operation via median sternotomy 38640
tumour, excision of 38670,38673,38677
38680
Cardiopexy, antireflux operation 30530
Cardioplegia, retrograde administration of 22070
Cardiopulmonary bypass, cannulation for 38600,38603
support procedures 13815,13818,13830
13839,13842,13847,13848,13851,13854,13857
Cardiotocography, antenatal (restriction) 16514
Cardioversion 13400
Carotid artery, aneurysm, graft replacement 33100
artery, internal, transection/resection 32703
body tumour, resection of 34148,34151,34154
cavernous fistula, obliteration of 39815
percutaneous transluminal angioplasty with stenting 35307
percutaneous transluminal angioplasty with stenting 35307
Carpal bone, replacement arthroplasty 46324,46325
ligament, transverse, division of 39331
resection arthroplasty 46325
scaphoid, fracture, treatment of 47354,47357
tunnel release 39331
Carpometacarpal joint, arthrodesis of 46303
joint, dislocation, treatment of 47030,47033
joint, synovectomy of 46342
Carpus dislocation, treatment of 47030,47033
fracture, treatment of 47348,47351
operation on, acute osteomyelitis 43503,46462
operation on, chronic osteomyelitis 43512,46462
osteectomy/osteotomy of 48406,48409
Caruncle, urethral, cauterisation of 35523
urethral, excision of 35526,35527
Cataract, juvenile, removal of 42716
surgery 42702
Catheter, peritoneal insertion and fixation 13109
epidural, insertion of 39140
placement of catheters and injection of opaque material 38243
tenckhoff peritoneal dialysis, removal of 13110
Catheterisation, bladder, independent procedure 36800
blood pressure monitoring 13876
cardiac 38200,38203,38206
38209,38212,38213,38215,38218,38220,38222
central vein 13318,13319,13815
central vein, subcutaneous tunnel 34527,34528
central vein, tunnelled cuffed 34538
eustachian tube 41755
frontal sinus 41740
intracranial, for pressure monitoring 13830
peripheral arterial 35317,35319-35321
peripheral venous 35317,35319,35320
peritoneal, for dialysis 13109,13110
pulmonary artery 13818
right heart balloon 13818
umbilical artery 13303
umbilical or scalp vein in a neonate 13300
ureteric, with cystoscopy 36824
cauterisation of, for ectropion or entropion 42581
coalition, excision of 50333
cyst, extirpation of 42575
Cauterisation, angioma (restriction applies) 45027
cervix 35608
perforation of tympanum 41641
septum/turbinates/pharynx 41674
tarsus, for ectropian/entropian 42581
urethra or urethral caruncle 35523
Cautery, conjunctiva, including treatment of pannus 42677
nasal, for arrest of haemorrhage 41677
Cavernous sinus, tumour or vascular lesion, excision 39660
Cavopulmonary shunt, creation of 38733,38736
Cellulitis, incision with drainage, under GA 30223
Central cannulation for cardiopulmonary bypass 38600
vein catheterisation 13318,13319,13815

vein catheterisation, via subcutaneous tunnel 34527,34528
Cerebello-pontine angle tumour 41575,41576,41578
41579
- retromastoid removal of 41575,41576,41578
41579
- translabyrinthine removal 41575,41576,41578
41579
- transmastoid removal 41575,41576,41578
41579
Cerebral palsy, hips or knees, application of cast
under GA 50390
perfusion, retrograde, cannulation for 38577
single event multilevel surgery 50450,50451,50455
50456,50460,50461,50465,50466,50470,50471,50475
50476
tumour, craniotomy for removal 39712
ventricle, puncture of 39006
Cerebrospinal fluid drain, lumbar, insertion of 40018
fluid reservoir, insertion of 39018
Cervical decompression of spinal cord 40331-40335
discectomy (anterior), without fusion 40333
oesophagectomy 30294
oesophagostomy, closure or plastic repair of 30293
re-exploration for hyperparathyroidism 30317
rib, removal of 34139
sympathectomy 35003,35006
Cervix, amputation or repair of 35617,35618
cauterisation of, other than by chemical means 35608
colposcopic examination of 35614
colposcopy with biopsy and diathermy 35646
cone biopsy of 35617,35618
diathermy of 35608,35646
electrocoagulation diathermy 35644,35645
ionisation of 35608
large loop excision 35647,35648
laser therapy (restriction applies) 35539,35542,35545
punch biopsy 35608
purse string ligation 16511
removal of polyp from 35611
removal of purse string ligature 16512
repair of extensive laceration/s 16571
repair of, not otherwise covered 35617,35618
residual stump, removal of, abdominal approach 35612
residual stump, removal of, vaginal approach 35613
Chalazion, extirpation of 42575
Chemical peel, full face 45019,45020
Chemotherapy 13915,13918,13921
13924,13927,13930,13933,13936
device for drug delivery, loading of 13939,13942,13945
device, insertion, central vein catheterisation 34527,34528
device, removal of 34530
infusion, cannulation for 34521,34524
Chest, or limb, decompression escharotomy 45054
Chloasma, full face chemical peel 45019,45020
Choanal atresia, repair/correction 45645,45646
Cholangiogram, percutaneous transhepatic 30440
Cholangiography, operative 30439
Cholangiopancreatography 30484
Cholecystectomy 30443,30445,30446
30448,30449
Cholecystoduodenostomy 30460,31472
Cholecystoenterostomy 30460,31472
Cholecystostomy 30375
Choledochal cyst, resection of 43972,43975
Choledochoduodenostomy 30460,30461
Choledochoenterostomy 30460,30461
Choledochogastrostomy 30461
Choledochojejunostomy 30460,30461
Choledochoscopy 30442,30452
Choledochotomy 30454,30455,30457
Chondro-cutaneous or chondro-mucosal graft 45656
Chondroplasty of knee 49503,49506
Chordee, correction of 37417
Chorionic villus sampling 16603
Chymopapain (Discase), intradiscal injection of 40336
Cicatricial flexion/extension contracture, joint,
correction 50112
Ciliary body and/or iris, excision of tumour 42767
Circulatory support device, management of 13851,13854
support procedures 38362,38600,38603
38609,38612,38613,38615,38618,38621,38624
Circumcision 30653,30656,30659
30660
arrest of post-operative haemorrhage 30663
Cisternal puncture 39003
shunt diversion, insertion of 40003
shunt, revision or removal of 40009
Clavicle, dislocation, treatment of 47003,47006
fracture, treatment of 47462,47465
operation for acute osteomyelitis 43503
operation for chronic osteomyelitis 43512
osteectomy/osteotomy 48406,48409
Claw toe, correction of 49848
Cleft lip, operations for 45677,45680,45683
45686,45689,45692,45695,45698,45701,45704
palate, correction of 45707,45710,45713
Clitoris, amputation of, medically indicated 35530
Clitoroplasty, reduction, ambiguous genitalia 37845,37848
Clival tumour, removal of 39653,39654,39656
39658
Cloaca, persistent, correction of 43969
Cloacal exstrophy, neonatal, operation for 43882
Club hand, radial, centralisation/radialisation 50399
Coccyx, excision of 30672
Cochlear implant, insertion with mastoidectomy 41617
Cochleotomy, or repair of round window 41614
Coeliac artery, decompression of 34142
Colectomy, subtotal, of large intestine 32004,32005
total, for Hirschsprung's, paediatric 43996
total, with excision rectum/anastomosis 32051,32054,32057
total, with excision rectum/ileostomy 32015,32018,32021
total, with ileo-rectal anastomosis 32012
total, with ileostomy 32009
Colles' fracture of radius, treatment of 47369,47372,47375
treatment of paediatric 50508,50512
Colonic atresia, neonatal, laparotomy for 43816
lavage, total, intra-operative 32186
reservoir, construction of 32029
Colonoscopy, fibreoptic 32084,32087,32090
32093
Colorectal strictures, endoscopic dilatation of 32094
Colostomy, closure of 30562
colostomy 30375
entero- 30515
refashioning of 30563
with laparotomy, neonatal anorectal malformation 43822
Colotomy 30375
Colpoperineorrhaphy 35571,35573
Colpopexy, sacral 35597
sacrospinous 35568
Colposcopy, using Hinselmann-type instrument 35614
with other procedures 35644-35647
Colpotomy 35572
Composite graft to nose, ear or eyelid 45656
Condylectomy 45611,48406,48424
of mandible 45611
Condylectomy/condylotomy 45863
Cone biopsy of cervix 35617,35618
Confinement 16515,16518-16520,16522
16525
Congenital absence of vagina, reconstruction for 35565
atresia, auditory canal reconstruction 45662

heart disease, operations for 38700,38703,38706
38709,38712,38715,38718,38721,38724,38727,38730
38733,38736,38739,38742,38745,38748,38751,38754
38757,38760,38763,38766
Conjunctiva, cautery of 42677
biopsy of 42676
cryotherapy to 42680
Conjunctival cysts, removal of 42683
graft over cornea 42638
lacerations not involving sclera 30032
peritomy 42632
Conjunctivorhinostomy 42629
Contour reconstruction, insertion of foreign implant 45051
restoration of face, autologous bone/cartilage graft 45647
Contraceptive device, intra-uterine, introduction of 35503
device, intra-uterine, removal under GA 35506
Contracted socket, reconstruction 42527
Contracture, cicatricial flexion/extension of joint,
correction 50112
Dupuytren's, subcutaneous fasciotomy for 46366
flexor/extensor, digits of hand, correction of 46492
Cordotomy, laminectomy for 39124
percutaneous 39121
Cornea, conjunctival graft over 42638
epithelial debridement for corneal ulcer/erosion 42650
epithelial debridement for keratoplasty 42651
removal of imbedded foreign body 42644
removal of superficial foreign body 30061
transplantation of 42653,42656,42659
Corneal, laser coagulation of blood vessels 42797
additional incisions for astigmatism 42673
incisions for astigmatism 42672
keratoplasty, epithelial debridement for 42651
perforations, sealing of 42635
scars, excision of 42647
suture, running, manipulation of 42667
sutures, removal of 42668
ulcer, epithelial debridement of cornea for 42650
Coronary artery bypass operations 38497,38498,38500
38501,38503,38504
angiography, selective 38215,38218,38220
38222,38225,38228,38231,38234,38237,38240,38241
38243,38246
artery bypass vein graft, dissection 38637
endarterectomy, open operation 38505
Coronary pressure wire 38241
Corpus callosum, anterior section of, for epilepsy 40700
Corticectomy, for epilepsy 40703
Corticolysis of lens material 42791,42792
Costo-transverse joint, injection into 39013
Counterpulsation, intra-aortic balloon, management 13847,13848
Cranial nerve, intracranial decompression of 39112
shunt diversion, insertion of 40003
shunt, revision or removal of 40009
vault reconstruction 45785
Craniectomy and removal of haematoma 39603
for osteomyelitis/removal infected bone 39906
Craniocervical junction lesion, transoral approach for 40315
Craniopharyngioma, craniotomy for removal of 39712
Cranioplasty and repair of fractured skull 39615
reconstructive 40600
Craniostenosis, operations for 40115,40118
Craniotomy and tumour removal 39709,39712
burr-hole for intracranial haemorrhage 39600
for arachnoidal cyst 39718
for hydromyelia (with laminectomy) 40342
for reopening post-op for haemorrhage/swelling 39721
Cricopharyngeal myotomy 41776
Cricothyrostomy 41884
Cruciate ligaments, reconstruction/repair 49536,49539,49542
Cryotherapy for detached retina 42773
for trichiasis 42587
hepatic, destruction of liver tumours 30419
of peripheral nerves 39323
of retina, with vitrectomy 42728
of skin lesions 30189,30192,30195
to haemorrhoids with rubber band ligation 32135
to nose, for haemorrhage 41680
to retina, independent procedure 42818
Crystalloid, retrograde admin for cardioplegia 38588
Curettage, for evacuation of gravid uterus 35643
uterus (D and C) 35639,35640
Cutaneous neoplastic lesions, treatment of 30195
nerve, nerve graft to 39318
nerve, repair of 39300,39303
ureterostomy, closure of 36621
vesical fistula, operation for 37023
vesicostomy, establishment of 37026
Cyclodestructive procedures treatment of glaucoma 42770,42771
Cyst, arachnoidal, craniotomy for 39718
Baker's, excision of 30114
Bartholin's, cautery destruction of 35516,35517
Bartholin's, excision of 35512,35513
Bartholin's, marsupialisation of 35516,35517
bone, injection into or aspiration of 47900
brain, operations for 39703
branchial, removal of 30286
broad ligament, excision of 35712,35713,35716
35717
bronchgenic, thoracotomy and excision 43912
choledochal, resection of 43972,43975
enterogenous, thoracotomy and excision 43912
epididymal, removal of 37601
fimbrial, excision of 35712,35713,35716
35717
hydatid, liver, treatment of 30434,30436-30438
hydatid, lungs, enucleation of 38424
intracranial, needling and drainage of 39703
kidney, removal from 36558
liver, laparoscopic marsupialisation 30416,30417
mucous, of mouth, removal 30282,30283
not otherwise covered, removal of (OMS) 45801,45803,45805
45807,45809
other, removal of 31200,31205,31210
31215,31220,31225,31230,31235,31240
ovarian, aspiration of 35518
ovarian, excision of, with laparotomy 35712,35713,35716
35717
pancreatic, anastomosis 30586,30587
parovarian, excision of, with laparotomy 35712,35713,35716
35717
pharyngeal, removal of 41813
pilonidal, excision of 30675,30676
renal, excision of 36558
skin/subcutaneous/mucous membrane, removal of31200,31205,31210
31215,31220,31225,31230,31235,31240
tarsal, extirpation of 42575
thyroglossal, removal of 30313,30314
vaginal, excision of 35557
vallecular, removal of 41813
Cystadenomatoid malformation, neonatal, thoracotomy 43861
Cystocoele, repair of 35570
Cystoscopy, with 36836
- controlled hydrodilatation of bladder 36827
- diathermy or resection of bladder tumour/s 36845
- endoscopic incision/resection 36825,36854
- injection into bladder wall 36851
- insertion of ureteric stent, or brush biopsy 36821
- insertion of urethral prosthesis 36811
- laser destruction of bladder tumours 36840
- lavage of blood clots from bladder 36842
- removal of foreign body 36833

- resection of ureterocele 36848
- ureteric catheterisation 36818,36824
- ureteric meatotomy 36830
- urethroscopy with/without urethral dilatation 36812
- without litholapaxy 36863
- without urethroscopy 36815

Cystostomy, suprapubic 37008
Cystotomy, suprapubic 37008,37011
Cytotoxic agent, instillation into body cavity 13948

D

D and C 35639,35640
Dacryocystectomy 42596
Dacryocystorhinostomy 42623,42626
Debridement of contaminated wound 30023
of tissue, ischaemic limb 35100,35103
Debulking operation, gynaecological malignancy 35720
Decompression fasciotomy, calf/forearm 47975,47978,47981
fasciotomy, hand 47981
of Arnold-Chiari malformation 40106
of facial nerve, mastoid portion 41569
of intracranial tumour 39706
operation for priapism 37393
subtemporal 40015
Deep organ, percutaneous aspiration biopsy 30094
tissue or organ, biopsy of 30074,30075,30078
Defibrillator generator, insertion/replacement 38393
insertion of patches for 38390
Delorme procedure 32111
Dermabrasion 45021,45024
Dermo-fat or fascia graft 45018
Dermoid, excision of
nasal, excision of 41729
oral and maxillofacial region 45801,45803,45805
45807
orbital, excision of 42574
periorbital, excision of 42573
Detached retina, diathermy/cryotherapy 42773
retina, removal of silicone band 42812
retina, resection/buckling/revision 42776
device for delivery of therapeutic agents 14221,14224,14227
14230,14233,14236,14239,14242
drug delivery system 39125,39126,39128
39133
drug delivery system for spasticity management14227,14230,14233
14236,14239,14242
pump or reservoir, loading of 14218
reservoir associated with adjustable gastric band 14215
Dialysis, peritoneal 13112
supervision in home 13104
supervision in hospital 13100,13103
Diaphragm, plication of for eventration 43915
Diaphragmatic hernia, neonatal, repair of 43837,43840
hernia, repair of 30600,30601
Diaphyseal aclasia, removal of lesion/s from bone 50426
Diastematomyelia, tethered cord, release of 40112
Diathermy of bladder tumours 36840,36845
cervix 35608,35646
detached retina 42773
electrocoagulation, of cervix 35644,35645
palmar or plantar wart 30186
perforation of tympanum 41641
pharynx 41674
rectal polyps with sigmoidoscopy 32078
salivary gland duct 30262
septum 41674
starburst vessels, head or neck 30213,30214
telangiectases, head or neck 30213,30214
turbinates 41674
urethra 37318
Digit, amputation of 46464,46465,46468
46471,46474,46477,46480
distal, excision of ganglion/mucous cyst 46495
extra, amputation of 46464
flexor/extensor contracture, correction of 46492
or ray, transposition/transfer, vascular pedicle 46507
synovectomy of tendon/s 46348,46351,46354
46357,46360
transposition/transfer, vascular pedicle 46507
Digital nail, toe, removal of 47904,47906
nerve, nerve graft to 39318
nerve, repair of 39300,39303
Direct flap repair 45209,45212,45215
45218,45221,45224
Disc, intervertebral, laminectomy for removal 40300
intervertebral, microsurgical discectomy of 40301
lesion, recurrent, laminectomy for 40303
lumbar intervertebral, total artificial replacement 48691-48693
Discectomy, cervical (anterior), without fusion 40333
microsurgical, of intervertebral disc/s 40301
percutaneous lumbar 48636
discontinuation of surgical procedure on medical groups 30001
Disimpaction of faeces under GA 32153
Dissection, lymph nodes of neck 31423,31426,31429
31432,31435,31438
Diverticulum, bladder, excision/obliteration 37020
Meckel's, removal of 30375
urethral, excision of 37372
Dohlman's operation 41773
Donald-Fothergill operation 35577
Donor haemapheresis 13755
Double balloon enteroscopy 30680,30682,30684
30686
Double balloon enteroscopy 30680,30682,30684
30686
Double vagina, excision of septum 35566
Drez lesion, operation for 39124
Drill biopsy of lymph gland/deep tissue/organ 30078
Drug delivery device, loading of 13939,13942,13945
drug delivery system for spasticity management14227,14230,14233
14236,14239,14242
Duct, salivary gland, diathermy/dilatation 30262
salivary gland, major, transposition of 41910
salivary gland, marsupialisation 30265,30266
salivary gland, meatotomy 30265,30266
salivary gland, removal of calculus 30265,30266
Ducts submandibular, removal of 30255
Duodenal atresia, duodeno-duodenostomy/jejunostomy 43807
intubation 30487,30488
stenosis, duodeno-duodenostomy/jejunostomy 43807
ulcer, perforated, suture 30375
Duodenoduodenostomy for duodenal atresia/stenosis 43807
Duodenojejunostomy for duodenal atresia/stenosis 43807
Duodenoscopy 30473,30476,30478
Dupuytren's contracture, operations for 46366,46369,46372
46375,46378,46381,46384,46387,46390,46393
Dysthyroid eye disease, decompression of orbit 42545

E

E.C.T. 14224
Ear, composite graft to 45656
drum perforation, excision of rim 41644
external, complex total reconstruction of 45660,45661
full thickness laceration, repair of 30052
full thickness wedge excision of 45665
lop, bat or similar deformity, correction of 45659
middle, clearance of 41635,41638
middle, exploration of 41629
middle, insertion of tube for drainage of 41632
middle, operation for abscess or inflammation of 41626

removal of foreign body from 41500,41503
toilet, using operating microscope 41647
Eclampsia, treatment of 16509
Ectopic bladder, 'turning-in' operation 37842
pregnancy, removal of 35676-35678
pregnancy, ultrasound guided needling and injection 35674
Ectropion, correction of 45626
tarsal cauterisation for 42581
Elbow, arthrodesis of 49106
arthroscopic surgery of 49121
arthroscopy of, diagnostic 49118
arthrotomy of 49100
dislocation, treatment of 47018,47021
flexorplasty/tendon transfer to restore function 50405
ligamentous stabilisation of 49103
radial head, replacement of 49112
revision arthroplasty 49116,49117
total replacement of 49115
total synovectomy of 49109
Electrical stimulation, maximal perineal stimulation, restoration cardiac rhythm 13400
Electroconvulsive therapy 14224
Electrode(s), epidural, insertion by laminectomy 39139
epidural, percutaneous insertion of 39130
epidural, percutaneous, management of 39131
graciloplasty, insertion of 32206
intracranial placement 40709,40712
myocardial, permanent, insertion, thoracotomy 38470
pacemaker, permanent, insertion sub xyphoid 38473
transvenous, insertion of 38256,38356
Electrolysis epilation, for trichiasis 42587
Electrophysiological studies, cardiac 38209,38212,38213
Embolectomy 33803,33806
Embolus, removal from artery of neck 33800
Emphysema, lobar, neonatal, thoracotomy & lung resection 43861
Empyema, intercostal drainage of 38806,38809
radical operation for 38415
Enbloc resection of tumour 50212,50215,50218 50221,50224,50227
Encephalocoele, excision and closure of 40109
Endarterectomy 33500,33506,33509 33512,33515,33518,33521,33524,33527,33530,33533 33536,33539,33542
coronary, open operation 38505
to prepare bypass site for anastomosis 33554
Endobronchial tumour, endoscopic laser resection 41901
endobronchial ultrasound, lung tumours 30710
Endocarditis, operative management of 38493
Endocrine tumour, exploration of 30578,30580,30581
Endolymphatic sac, transmastoid decompression 41590
Endometrial biopsy for suspected malignancy 35620
Endometriosis, laparoscopic ablation 35638
Laparoscopic resection of 35641
Endometrium, ablation of, endoscopic 35622
ablation of, by radiofrequency electrosurgery 35616
biopsy of for suspected malignancy 35620
biopsy of with hysteroscopy 35630
biopsy of, with IUD insertion for idiopathic menorrhagia 35502
endoscopic examination and ablation by microwave or thermal balloon 35616
Endoscopic biliary dilatation 30494
cholangio-pancreatography 30484
dilatation of colorectal strictures 32094
examination of intestinal conduit/reservoir 36860
examination of small bowel 30569,32095
gastrostomy, percutaneous 30481,30482
incision/resection, external sphincter/bladder neck 36854
laser ablation of prostate 37207,37208
laser resection of endobronchial tumours 41901
laser therapy of gastrointestinal tract 30479
manipulation/extraction of ureteric calculus 36857
prostatectomy 37203,37206
resection of pharyngeal pouch 41773
sphincterotomy 30485
stenting of bile duct 30491
transanal endoscopic microsurgery 32103,32104,32106
ultrasound 30688,30690,30692 30694
Endoscopic ultrasound fine needle aspiration 30696
Endoscopy with balloon dilatation gastric stricture 30475
Enterocoele, repair of 35571
Enterocolitis, acute neonatal necrotising, laparotomy 43828,43831
necrotising stricture, bowel resection 43834
Enterocolostomy 30515
Enterocutaneous fistula, radical repair of 30382
Enteroenterostomy 30515
Enterostomy, closure of 30562
enterostomy 30375
Enterotomy, intra-operative, for endoscopy 30568
enterotomy 30375
Entropion, correction of 45626
repair of 42866
Enucleation of eye 42506,42509
hydatid cysts of lung 38424
Epicondylitis, open operation for 47903
Epididymal cyst, excision of 37601
Epididymectomy 37613
Epidural blood patch 18233
catheter, insertion of 39140
electrode, insertion 39130,39139
electrode, management, adjustment etc. 39131
implant, removal of 39136
stimulator, revision of 39133
Epigastric hernia, repair of 30616,30617,30620 30621
Epilation electrolysis, for trichiasis 42587
Epilepsy, operations for 40700,40703,40706 40709,40712
Epiphyseal arrest 48500,48503,48506 48509
plate, prevention of closure 48512
Epiphysiodesis, femur/fibula/tibia 48500,48503,48506
staple arrest of hemi-epiphysis 48509
Epiphysiolysis, to prevent closure of plate 48512
Epispadias, repair of 37836,37839,37842
Epistaxis, treatment of 41656,41677,41680
Epithelial debridement for corneal ulcer/erosion 42650
debridement/eliminating band keratyoplasty 42651
ESWL 36546
Ethmoidal artery, transorbital ligation of 41725
sinuses, operation on 41737,41749
Ethmoidectomy, fronto-nasal 41731
fronto-radical 41734
transantral, with radical antrostomy 41713
Etonogestral, subcutaneous implant, removal of 30062
Eustachian tube, catheterisation of 41755
obliteration of 41564
Evacuation of retained products of conception 16564
Eventration, plication of diaphragm for 43915
Evisceration of globe of eye 42512,42515
excision of, with melanoma 31340
Exenteration of orbit of eye 42536
Exomphalos, neonatal, operations for 43870,43873
Exostoses in external auditory meatus, removal 41518
Exostosis, excision of 47933,47936
mandibular or palatal 45825
Exstrophy, cloacal, neonatal, operation for 43882
of bladder, closure 37050
of bladder, repair of 37842
Extensor tendon of hand or wrist, repair of 46420,46423

tendon of hand, tenolysis of 46450
tendon, synovectomy of 46339
External auditory canal, reconstruction 41524,45662
auditory meatus, removal of exostoses 41518
cephalic version 16501
ear, complex total reconstruction of 45660,45661
fixation, orthopaedic, removal 47948,47951
stent, application 34824,34827,34830
34833
External cephalic version 16501
Extra digit, amputation of 46464
Extracardiac conduit, insertion/replacement 38757,38760
Extracorporeal shock wave lithotripsy 36546
Extracranial to intracranial bypass 39818,39821
Extradural tumour or abscess, laminectomy for 40309
Eye, capsulotomy, laser 42788,42789
coagulation, laser, of corneal/scleral blood vessels 42797
conjunctiva, cautery of 42677
conjunctival graft 42638
corticolysis, laser, of lens material 42791,42792
dermoid, excision of 42573,42574
division of suture, laser 42794
enucleation of 42506,42509,42510
fibrinolysis 42791,42792
foreign body in cornea or sclera, removal of 42644
foreign body in, removal of 42560,42563,42566
42569
foreign body in, superficial, removal of 30061
globe of, evisceration of 42512
iridotomy, laser 42785,42786
iris tumour, laser photocoagulation 42806
laser photocoagulation 42806
orbit, insert/remove implant 42518
paracentesis 42734
phototherapeutic keratectomy, laser 42810
pinguecula, surgical excision 42689
radioactive plaques, construction,insertion & removal42801,42802
tantalum marker, insertion and removal 42805
trabeculoplasty, laser 42782
vitreolysis, laser, of lens material 42791
Eyeball, repair of perforating wound 42551,42554,42557
Eyebrow, elevation of 42872
Eyelashes, ingrowing, operation for 45626
Eyelid closure in facial nerve paralysis, implant
insertion 42869
composite graft to 45656
ectropion or entropion, correction of 45626
full thickness laceration, repair of 30052
full thickness wedge excision of 45665
grafting for symblepharon 45629
ptosis, correction of 45623
reconstruction of, whole thickness 45614,45671,45674
reduction of 45617,45620
removal of cyst from 42575
tarsorrhaphy 42584
upper recession of 42863

F

Face, injections of poly-L-Lactic acid 14201
Face, repair of complex fractures 45753,45754
chemical peel 45019,45020
Facet joint denervation by percutaneous neurotomy 39118
Facial, nerve, decompression of 41569
nerve palsy, excision of tissue for 45581
nerve paralysis, plastic operation for 45575,45578
scar, revision of (restriction applies) 45506,45512
Facio-hypoglossal/accessory nerve, anastomosis of 39503
Faecal incontinence, sacral nerve stimulation for 32213-32218
Fallopian tubes, catheterisation, with hysteroscopy 35633
tubes, hydrotubation of 35703,35709
tubes, implantation of, into uterus 35694,35697
tubes, microsurgical anastomosis 35700
tubes, Rubin test for patency 35706
tubes, sterilisation 35687,35688
tubes, sterilisation with Caesarean section 35691
Falloposcopy, unilateral/bilateral 35710
Fascia, deep, repair of, for herniated muscle 30238
graft 45018
Fasciectomy, for Dupuytren's Contracture 46369,46372,46375
46378,46381,46384,46387,46390,46393
Fasciotomy, forearm or calf 47975,47978,47981
interosseous muscle space of hand 47981
muscle 30226
plantar, radical 49854
subcutaneous, Dupuytren's contracture 46366
Femoral hernia, repair of 30609,30612,30614
vein puncture in infants, blood collection 13312
vessel, ligation/exploration, other 34103
Femoro-femoral crossover bypass grafting 32718
graft, infected, excision of 34172
Femur, bone graft to 48200,48203
congenital deficiency, treatment of 50411,50414
drill decompression of head/neck or both 47982
epiphyseodesis 48500,48506
fracture, treatment of 50576
fracture, treatment of 47516,47519,47522
47525,47528,47531,47534,47537,49336
operation on, for osteomyelitis 43506,43515
osteectomy/osteotomy 48424,48427
Fetal blood sampling 16606
fluid filled cavity, drainage of 16624
intraperitoneal blood transfusion 16612,16615
intravascular blood transfusion 16609
Feto-amniotic shunt, insertion of 16627
Fibreoptic bronchoscopy 41898
colonoscopy 32084,32087,32090
32093
Fibrinolysis 42791,42792
Fibula, congenital deficiency, transfer fibula to tibia 50423
epiphyseodesis 48503,48506
fracture, treatment of 47576
fracture, treatment of paediatric 50588
operation on, for osteomyelitis 43503,43512
osteectomy/osteotomy 48406,48409
Filtering and allied operations for glaucoma 42746
Fimbrial cyst, removal of 35712,35713,35716
35717
Finger, amputation of 46465,46468,46471
46474,46477,46480,46483
digital nail, removal of 46513,46516
dislocation, treatment of 47036,47039
flexor tendon sheath, open operation 46522
fracture, treatment of 47300,47303,47306
47309,47312,47315,47318,47321,47324,47327,47330
47333
ingrowing nail, resection of 46528,46531
mallet, fixation/repair 46438,46441
percutaneous tenotomy of 46456
trigger, correction of 46363
Fissure in ano, operation for 32150
Fistula, alimentary, repair of 35596
anal, excision/repair 32159,32162,32165
32166
antrobuccol, operation for 41722
aorto-duodenal, repair of 34160,34163,34166
arteriovenous, dissection, ligation 34112,34115,34118
arteriovenous, dissection, repair 34121,34124,34127
34130
arteriovenous, ligation cervical vessel/s 39812
branchial, removal of 30289
carotid-cavernous, obliteration of 39815

cutaneous, salivary gland, repair of 30269
enterocutaneous, radical resection 30382
genito-urinary, repair 35596
in ano, subcutaneous, excision of 32156
oro-antral, plastic closure of 41722
parotid gland, repair of 30269
sacrococcygeal, excision of 30675,30676
thyroglossal, radical removal of 30314
tracheo-oesophageal, division and repair 43900
urethral, closure of 37833
urethro-rectal 37336
urethro-vaginal 37333
vesical, cutaneous, operation for 37023
vesico-intestinal, closure of 37038
vesico-vaginal, closure of 37029
wound, review under GA, independent 32168
Fixation, external, removal of 47948,47951
internal, of spine 48678,48681,48684
48687,48690
Flap
abbe 45701,45704
direct, indirect or local, revision of 45239,45240
free tissue transfer, revision of 45496-45499
indirect 45227,45230,45233
45236
myocutaneous, delay of 45015
myocutaneous, for breast reconstruction 45530
neurovascular island 45563,46504
pharyngeal, for velo-pharyngeal incompetence 45716
repair - H-flap or double advancement 45207
repair, direct 45209,45212,45215
45218,45221,45224
repair, local, single stage 45200,45203,45206
repair, muscle, single stage 45000,45003,45006
45009,45012
revision of, by incision and suture 45239
revision of, by liposuction 45240
Flexor tendon, hand, repair of 46426,46429,46432
46435
tendon pulley, reconstruction 46411
tendon sheath, finger or thumb, open operation 46522
tendon, hand, tenolysis of 46453
tendon, hand/wrist, synovectomy of 46339
tendon, wrist, repair of 46426,46429
tendon/s, digit, synovectomy of 46348,46351,46354
46357,46360
Flexorplasty to restore elbow function 50405
Fluid Filled Cavity, drainage of 16624
Foot, amputation or disarticulation of 44359,44361,44364
and ankle, tibialis tendon transfer 50339,50342
arthrodesis of 49815,49845
calcaneal spur, excision of 49818
claw or hammer toe, correction of 49848,49851
hallux valgus or hallux rigidus, correction of 49821,49824,49827
49830,49833,49836-49839,49842
metatarso-phalangeal joint, replacement of 49857
metatarso-phalangeal joint, synovectomy of 49860,49863
neurectomy for plantar digital neuritis 49866
paronychia of, pulp space infection, incision 47912
radical plantar fasciotomy or fasciectomy of 49854
tendon of, repair of 49800,49803
tendon or ligament transplantation of 49812
tenotomy of 49806,49809
tibialis tendon transfer 50339,50342
For anaesthesia 20100,20102,20104
20120,20124,20140,20142-20148,20160,20162,20164
20170,20172,20174,20176,20190,20192,20210,20212
20214,20216,20220,20222,20225,20230,20300,20305
20320,20321,20330,20350,20352,20355,20400-20406
20410,20420,20440,20450,20452,20470,20472,20474
20475,20500,20520,20522,20524,20526,20528,20540
20542,20546,20548,20560,20600,20604,20620,20622
20630,20632,20634,20670,20680,20690,20700
20702-20706,20730,20740,20745,20750,20752,20754
20756,20770,20790-20794,20798-20800,20802-20806
20810,20815,20820,20830,20832,20840-20842
20844-20848,20850,20855,20860,20862-20864
20866-20868,20880,20882,20884,20886,20900,20902
20904-20906,20910-20912,20914,20916,20920,20924
20926,20928,20930,20932,20934,20936,20938,20940
20942-20944,20946,20948,20950,20952-20954,20956
20958,20960,21100,21110,21112,21114,21116,21120
21130,21140,21150,21155,21160,21170,21195,21199
21200,21202,21210,21212,21214,21216,21220,21230
21232,21234,21260,21270,21272,21274,21275,21280
21300,21321,21340,21360,21380,21382,21390,21392
21400,21402-21404,21420,21430,21432,21440,21445
21460-21462,21464,21472,21474,21480,21482,21484
21486,21490,21500,21502,21520,21522,21530,21532
21535,21600,21610,21620,21622,21630,21632,21634
21636,21638,21650,21652,21654,21656,21670,21680
21682,21685,21700,21710,21712,21714,21716,21730
21732,21740,21756,21760,21770,21772,21780,21785
21790,21800,21810,21820,21830,21832,21834,21840
21842,21850,21860,21865,21870,21872,21878-21887
21900,21906,21908,21910,21912,21914-21916,21918
21922,21925-21927,21930,21935,21936,21939
21941-21943,21945,21949,21952,21955,21959,21962
21965,21969,21970,21973,21976,21980,21981,21990
21992,21997,22001,22002,22007,22008,22012,22014
22015,22018,22020,22025,22031,22036,22040,22045
22050,22051,22055,22060,22065,22070,22075,22900
22905,23010,23021-23023,23031-23033,23041-23043
23051-23053,23061-23063,23071-23073,23081-23083
23091,23101,23111-23119,23121,23170,23180,23190
23200,23210,23220,23230,23240,23250,23260,23270
23280,23290,23300,23310,23320,23330,23340,23350
23360,23370,23380,23390,23400,23410,23420,23430
23440,23450,23460,23470,23480,23490,23500,23510
23520,23530,23540,23550,23560,23570,23580,23590
23600,23610,23620,23630,23640,23650,23660,23670
23680,23690,23700,23710,23720,23730,23740,23750
23760,23770,23780,23790,23800,23810,23820,23830
23840,23850,23860,23870,23880,23890,23900,23910
23920,23930,23940,23950,23960,23970,23980,23990
24100-24136,25000,25005,25010,25015,25020,25025
25030,25050,25200,25205
Foramen Magnum, tumour or vascular lesion, excision 39662
Forearm, amputation or disarticulation of 44328
decompression fasciotomy of 47975,47978,47981
fracture, treatment of 47378,47381,47384-47387
47390,47393
fracture, treatment of paediatric 50500,50504,50508
50512,50516,50520,50524,50528,50532,50536,50540
50544,50548
radial aplasia/dysplasia, centralisation/radialisation 50399
Foreign body, antrum, removal of 41716
bladder, cystoscopic removal of 36833
bronchus, removal of 41895
cornea or sclera, imbedded, removal of 42644
cornea or sclera, superficial, removal of 30061
ear, removal of 41500,41503
implant, contour reconstruction, insertion 45051
intra-ocular, removal of 42560,42563,42566
42569
maxillary sinus, removal of 41716
muscle/deep tissue, removal of 30067,30068
nose, removal of 41659
oesophagus, removal of 41825
subcutaneous, removal of 30064
superficial, removal of 30061
tendon, removal of 30067,30068

trachea, removal of 41886
urethra, removal of 37318
Free grafts 45400,45403,45406
45409,45412,45415,45418,45439,45442,45445,45448
45451,45460-45462,45464-45466,45468,45469,45471
45472,45474,45475,45477,45478,45480,45481
45483-45494
split skin, to burns 45460-45462,45464-45466,45468
45469,45471,45472,45474,45475,45477,45478,45480
45481,45483-45493
transfer of tissue 45562-45565
transfer of tissue, anastomosis artery/vein 45502
Frenulum, mandibular or maxillary, repair 30281
Frontal sinus, catheterisation of 41740
sinus, intranasal operation on 41737
sinus, radical obliteration of 41746
sinus, trephine of 41743
Fronto-ethmoidectomy, radical 41734
Fronto-nasal ethmoidectomy 41731
Fronto-orbital advancement 45782,45785
Full thickness grafts, free 45451
thickness wedge excision of lip, eyelid or ear 45665
Fundoplasty/plication, antireflux operation 30527,30529,30530
antireflux operation by 31464,31466
Funnel chest, elevation of 38457,38458
Furuncle, incision with drainage of 30219,30223
Fusion, spinal, cervical/thoracic/lumbar 48660,48663,48666
48669,48672,48675
spinal, posterior interbody 48654,48657
vertebral body, diseases of 48640

G

Gallbladder, drainage of 30375
excision of 30443,30445,30446
30448,30449
Galvanocautery of skin lesions 30192
Gamete intra-fallopian transfer 13200,13203,13206
13209,13212,13215,13218,13221
Ganglion, excision of 30106,30107
hand, excision of 46494,46495,46498
wrist joint, excision of 46500-46503
Gangliotomy, radiofrequency trigeminal 39109
Gangrenous tissue, debridement of 35100,35103
Gartner duct cyst, removal of 35557
Gastrectomy, partial 30518
sub-total, radical, for carcinoma 30523
total 30521,30524,30526
Gastric by-pass for obesity 30512
band, in association with implanted resevoir 14215,31441
hypothermia 13500,13503
lavage in the treatment of ingested poison 14200
reconstruction with oesophagectomy 30535
reduction for obesity 30511
stricture, endoscopy with balloon dilatation 30475
tumour, removal of 30520
ulcer, perforated, suture 30375
Gastro-camera investigation 30473
Gastro-oesophageal balloon intubation 13506
reflux, operations for 43951,43954,43957
Gastroduodenal stricture, balloon dilatation 30475
Gastroduodenostomy 30515
reconstruction of 30517
Gastroenterostomy 30515
reconstruction of 30517
Gastrointestinal blood loss estimation
tract, dilatation of stricture of upper 41819,41820
Gastroschisis, operations for 43864,43867
Gastroscopy 30473,30476,30478
insertion of nasogastric/nasoenteral tube 31456,31458
Gastrostomy button, non-endoscopic
insertion/replacement 30483
gastrosomy 30375
percutaneous endoscopic 30481,30482
percutaneous tube, jejunal extension 31460
Genioplasty 45761
Gilliam's operation 35683,35684
Gland, adrenal, excision of 36500
Bartholin's, marsupialisation of 35516,35517
lacrimal, excision of palpebral lobe 42593
lymph, biopsy of 30074,30075
lymph, drill biopsy of 30078
lymph, pelvic, excision of 35551
lymph, pelvic, excision of, with hysterectomy 35664
parotid, superficial lobectomy/tumour removal 30253
parotid, total extirpation of 30247,30250
salivary, duct, dilatation or diathermy of 30262
salivary, duct, marsupialisation 30265,30266
salivary, duct, meatotomy 30265,30266
salivary, duct, removal of calculus 30265,30266
salivary, operations on 30262,30265,30266
30269
sublingual, extirpation of 30259
submandibular, extirpation of 30256
Glaucoma, filtering and allied operations for 42746,42749
iridectomy and sclerectomy for 42746
iridectomy or iridotomy 42764
Molteno valve, insertion of 42752
Molteno valve, removal of 42755
Glenoid fossa, reconstruction of 45788
Glioma, craniotomy for removal of 39709
Globe of eye, evisceration of 42512,42515
Glomus tumour, transmastoid removal of 41623
tumour, transtympanic, removal of 41620
Glossectomy, with partial pharyngectomy 41785
Gonadal dysgenesis, vaginoplasty for 37851
Goniotomy 42758
Graciloplasty procedures 32200,32203,32206
32209,32210
Grafenberg's (or Graf) ring, introduction of 35503
ring, removal under GA 35506
Graft, axillo-femoral, infected, excision of 34172
bypass, for occlusive arterial disease 32700,32703,32708
32710-32712,32715,32718,32721,32724,32730,32733
32736,32739,32742,32745,32748,32751,32754,32757
32760,32763
composite (chondro-cutaneous/mucosal) 45656
conjunctival over cornea 42638
corneal 42653,42656,42659
dermis, dermo-fat or fascia 45018
femoro-femoral, infected, excision of 34172
free fascia for facial nerve paralysis 45575,45578
free, split skin 45400,45403,45406
45409,45412,45415,45418,45439,45442,45445,45448
45451,45460-45462,45464-45466,45468,45469,45471
45472,45474,45475,45477,45478,45480,45481
45483-45494
inlay, using a mould 45445
micro-arterial or micro-venous 45503
nerve 39315,39318
skin, to orbit 42524
Grafting, bypass, occlusive arterial disease
for symblepharon 45629
patch, to artery or vein 33545,33548
Granuloma, cautery of 42677
removal from eye, surgical excision 42689
umbilical, excision under GA 43948
Gravid uterus, evacuation of contents by curettage 35643
Great vessel, intrathoracic operation on, other 38456
vessel, ligation or exploration, other 34103
Greater trochanter, transplant of ileopsoas tendon 50121
Groin, lymph, excision of 30329,30330

Grommet, free, in canal, removal of
in situ in drum, removal of 41500
insertion of 41632
Gunderson flap operation 42638
Gynaecological examination under GA 35500
Gynatresia, vaginal reconstruction for 35565

H

Haemangioma, cauterisation of (restriction) 45027
excision of 45030,45033,45035
45036
of neck, deep-seated, excision of 45036
Haemapheresis 13750,13755
Haematoma, aspiration of 30216
breast, exploration and drainage 31551
incision and drainage, without GA 30219
large, incision and drainage, with GA 30223
pelvic, drainage of 30387
Haemochromatosis 13757
Haemodialysis, in hospital 13100,13103
central vein, tunnelled cuffed catheter 34538
removal of tunnelled cuffed catheter 34539
Haemofiltration, continuous (ICU) 13885,13888
in hospital 13100,13103
Haemoperfusion, in hospital 13100,13103
Haemorrhage, antepartum, treatment of 16509
arrest of
- following circumcision, with GA 30663
- following tonsillectomy, with GA 41796,41797
extremity, reoperation for control of 33848
intracranial, burr-hole craniotomy for 39600
nasal, arrest of 41656,41677
nasal, cryotherapy for treatment of 41680
post-op, control under GA, independent 30058
post-operative, following gynaecological surgery 35759
post-operative, laparotomy for 30385
postpartum, treatment of 16567
subdural, tap for 39009
Haemorrhoidectomy 32138,32139
Haemorrhoids, injection into
removal of 32138,32139
rubber band ligation of 32135
sclerotherapy for 32132
Hair transplants, congenital/traumatic alopecia 45560
Hallux rigidus/valgus, correction of 49821,49824,49827
49830,49833,49836-49839,49842
Halo, application 47711,47714
femoral traction, application of 47720,47723
thoracic traction, application of 47717
Hammer toe, correction of 49848
Hand, amputation or disarticulation of 44325,44328
arthrotomy 46327,46330
bone grafting for pseudarthrosis 46405
congenital abnormalities, amputation of phalanges 50396
congenital abnormalities, splitting of phalanges 50396
decompression fasciotomy 47981
digits, flexor/extensor contracture, correction 46492
duplication of digits, amputation of phalanges 50396
duplication of digits, splitting of phalanges 50396
extensor tendon of, repair of 46420,46423
extensor tendon of, tenolysis of 46450
flexor tendon of, repair of 46423,46426,46429
46432,46435
flexor tendon of, tenolysis of 46453
ganglion, excision of 46494
middle palmar/thenar/hypothenar spaces, drainage 46519
osteectomy/osteotomy 46396,46399
paronychia/pulp space infection, incision for 46525
tendon sheath, operation for tendovaginitis 46363
tendon transfer for restoration of function 46417
Hartmann's operation 32030
Heart arrhythmia, ablation of 38287,38290,38293
arrhythmia, surgery for 38287,38290,38293
38390,38393,38512,38515,38518
catheterisation of 38200,38203,38206
electrical stimulation of 13400
intrathoracic operation on, not otherwise covered 38456
mitral annulus, reconstruction after decalcification 38485
subvalvular structures, reconstruction, re-implantation 38490
surgery for congenital heart disease 38700,38703,38706
38709,38712,38715,38718,38721,38724,38727,38730
38733,38736,38739,38742,38745,38748,38751,38754
38757,38760,38763,38766
surgery, open, not otherwise covered 38653
valve replacement 38488,38489
valve, repair 38480,38481
Heller's operation 30532,30533
Hemiarthroplasty, hand 46309,46312,46315
46318,46321
knee 49517
Hemicircumcision, for hypospadias 37354
Hemicolectomy 32000,32003,32006
Hemiepiphysis, staple arrest of 48509
Hemifacial microsomia, construction condyle and ramus 45791
Hemilaryngectomy, vertical, with tracheostomy 41837
Hemispherectomy, for intractible epilepsy 40706
Hemithyroidectomy 30306
Hemivulvectomy 35536
Hepatic duct, common, resection for carcinoma 30463,30464
artery catheterisation for SIRT 35406,35408
duct, common, repair of 30472
ducts, Roux-en-Y bypass 30466,30467
metastases, selective internal radiation therapy for35404,35406,35408
Hepatocellular carcinoma
destruction by radiofrequency ablation 50950,50952
Hernia, antireflux operations for 30527,30529,30530
diaphragmatic, neonatal, repair of 43837,43840
diaphragmatic, repair of 30600,30601
femoral or inguinal, repair of 30609,30612,30614
inguinal, repair, age less than 3 months 44108,44111,44114
spigelian, repair of 30403,30405
strangulated, incarcerated or obstructed, repair of 30615
umbilical, epigastric, or linea alba, repair of 30616,30617,30620
30621
ventral or incisional, repair of 30403,30405
ventral, following closure exomphalos, repair of 43939
Herniated muscle, fascia, deep, repair of 30238
Hiatus hernia, antireflux operations for 30527,30529,30530
hernia, repair of 30601
para-oesophageal, repair of 31468
Hickman catheter, insertion of, for chemotherapy 34527,34528
catheter, removal of 34530
High dose rate brachytherapy 37227
Hindquarter, amputation or disarticulation of 44373
Hinselmann colposcope, examination uterine cervix 35614
Hip, amputation or disarticulation at 44370
arthrectomy 49309,49312
arthrodesis 49306
arthroplasty 49309,49312,49315
49318,49319,49321,49324,49327,49330,49333,49336
49339,49342,49345,49346
arthroplasty, revision 49346
arthroscopy 49360,49363,49366
arthrotomy 49303
congenital dislocation, open reduction 50351
contracture of, medial/anterior release 50375,50378,50381
50384
dislocation, acetabulum fracture, treatment 47495,47498
dislocation, congenital, treatment of 50349,50352
dislocation, congenital, treatment of including
paediatric 50650,50654,50658

dislocation, treatment of 47048,47051
iliopsoas tendon transfer to greater trochanter 50387
prosthesis, operation on 49315
replacement procedures 49318,49319,49321
49324,49327,49330,49333,49336,49339,49342,49345
spica, application of 47540,50564
spica, application, congenital dislocation 50353,50564
transfer of abdominal musculature to greater trochanter 50387
transfer of adductors to ischium 50387
treatment of including paediatric 50650,50654,50658
Hirschsprung's disease, colostomy/enterostomy for 30375
disease, neonatal, laparotomy for 43819
disease, paediatric, operations for 43990,43993,43996
43999
Home, dialysis 13104
Hormone implantation, by cannula 14206
implantation, direct, incision and suture 14203
Humerus, bone graft to 48212,48215
fracture, treatment of 50552,50556,50560
50564,50568,50572
fracture, treatment of 47411,47414,47417
47420,47423,47426,47429,47432,47435,47438,47441
47444,47447,47450,47451,47453,47456,47459
operation for osteomyelitis 43506,43515
osteectomy/osteotomy 48412,48415
Hummelsheim type muscle transplant, squint 42848
Hydatid cyst, liver, total excision of 30437,30438
cyst, liver, removal of contents of 30434,30436
cyst, lungs, enucleation of 38424
Hydradenitis, excision for 31245
Hydrocele, infantile, repair of 30612,30614
removal of 30631
tapping of 30628
Hydrocephalus, operations for 40000,40003,40006
40009
Hydrocortisone, injections into keloid with GA 30210
Hydrodilatation of bladder with cystoscopy 36827
Hydromyelia, operations for 40339,40342
Hydrotubation of Fallopian tubes 35703,35709
Hymenectomy 35509
Hyperbaric oxygen therapy 13020,13025,13030
Hyperemesis gravidarum, treatment of 16505
Hyperextension deformity of toe, release, lengthening 50345
Hyperhidrosis, axillary, excision for 30180,30183
Hyperparathyroidism, operations for 30315,30317,30318
30320
Hyperplasia, papillary, of palate, removal of 45831,45833,45835
Hypertelorism, correction, intra/sub-cranial 45767,45770
Hypertension, portal, treatment of 30602,30603,30605
30606
Hypertrophied tissue, removal of 45801,45803,45805
45807
Hypospadias, examination under GA 37815
granuloplasty, meatal advancement 37818
meatotomy and hemi-circumcision 37354
penis erection test with examination 37815
repair of 37821,37824,37827
37830,37833
urethral fistula repair 37833
Hypothenar spaces of hand, drainage of 46519
Hypothermia, gastric 13500,13503
deep hypothermic circulatory arrest 22075
total body 22065
Hysterectomy 35653,35657,35658
35661,35664,35667,35670,35673
laparoscopically assisted 35750,35753,35754
35756
with ovarian transposition, malignancy 35729
Hysteroscopic resection of myoma or uterine septum 35623,35634
resection of uterine septem 35634
Hysteroscopy 35626,35627,35630
35633-35636
Hysterotomy 35649

I

Ileal atresia, neonatal, laparotomy for 43816
Ileo-femoral by-pass grafting 32712,32718
endarterectomy 33521
Ileorectal anastomosis 32012
Ileostomy 32009,32012,32015
32018,32021
closure of, with rectal resection 32060,32063,32066
closure of, without resection of bowel 30562
refashioning of 30563
reservoir, continent type, creation of 32069
with proctocolectomy 32015
with total colectomy 32009
Iliac endarterectomy 33518
vein, thrombectomy 33810,33811
vessel, ligation or exploration not otherwise covered 34103
Iliopsoas tendon transfer to greater trochanter 50387
Implanon, removal of 30062
Implant, cochlear, insertion of 41617
epidural, for pain management, removal of 39136
foreign, insertion for contour reconstruction 45051
insertion or removal from eye socket 42518
Implantable Cardioverter Defibrillator 38371,38384,38387
implantable bone conduction hearing system 41603,41604
Implantation, fallopian tubes into uterus 35694,35697
hormone or living tissue 14203,14206
Impotence, injection for investigation/treatment 37415
Incidental appendicectomy 30574
Incisional hernia, repair of 30403
Incomplete confinement 16518
Incontinence, anal, Parks' intersphincteric procedure 32126
bladder stress, suprapubic operation 37044
male urinary, injection for treatment of 37339
stress, sling operation for 35599
Indirect flap 45227,45230,45233
45236,45239
Induction, management, second trimester labour 16525
Indwelling oesophageal tube, gastrostomy for fixation 30375
Infantile hydrocele, repair of 30612,30614
Infection, acute intercurrent, complicating pregnancy 16508
Inferior vena cava, thrombectomy 33810,33811
vena caval filter, insertion of 35330
Inflammation of middle ear, operation for 41626
Infliximab 14245
Infliximab 14245
Infusion chemotherapy 13915,13918,13921
13924,13927,13930,13933,13936
chemotherapy, cannulation for 34521,34524
device, automated, spinal, insertion of 39125-39128
intra-arterial, sympatholytic agent 14209
Ingrowing eyelashes, operation for 45626
nail of finger or thumb, resection of 46528,46531
nail of toe, resection of 47915,47916
Inguinal abscess, incision of 30223
hernia, repair of 30609,30612,30614
hernia, repair, age less than 3 months 44108,44111,44114
Injection, alcohol, etc, around nerve or in muscle
alcohol, cortisone, phenol into trigeminal nerve 39100
alcohol, retrobulbar 42824
hormones, for habitual miscarriage 16504
into angioma (restriction applies) 45027
into prostate 37218
into spinal joints or nerves 39013
sclerosant fluid into pilonidal sinus 30679
Injections, multiple, for skin lesions 30207
Inlay graft, using a mould 45445
Innocent bone tumour, excision of 30241

Innominate artery, endarterectomy of 33506
insertion of, for drainage of middle ear 41632
Insufflation Fallopian tubes, for patency (Rubin test) 35706
Intensive care management/procedures 13815,13818,13830
13839,13842,13847,13848,13851,13854,13857,13870
13873,13876,13881,13882,13885,13888
Intercostal drain, insertion of 38806,38809
Internal auditory meatus, exploration of 41599
drainage of empyema, without rib resection 38806,38809
Interosseous muscle space of hand, fasciotomy of 47981
Interphalangeal joint, arthrodesis of 46300
joint, arthrotomy of 46327,46330
joint, dislocation, treatment of 47036,47039
joint, hemiarthroplasty 46309,46312,46315
46318,46321
joint, interposition arthroplasty of 46306
joint, joint capsule release of 46381
joint, ligamentous repair 46333
joint, synovectomy/capsulectomy/debridement 46336
joint, total replacement arthroplasty of 46309,46312,46315
46318,46321
joint, volar plate arthroplasty 46307
Interscapulothoracic amputation or disarticulation 44334
Interventional endovascular procedures 35300,35303,35306
35307,35309,35312,35315,35317,35319-35321,35324
35327,35330
Intervertebral disc/s, laminectomy for removal of 40300
disc, lumbar, total artificial replacement 48691-48693
disc/s, microsurgical discectomy of 40301
Intestinal conduit or reservoir, endoscopic examination 36860
duct, patent vitello, excision of 43945
malrotation, neonatal, laparotomy for 43801,43804
obstruction, surgical relief of 30387
plication, Noble type, with enterolysis 30375
remnant, abdominal wall vitello, excision of 43942
resection, large 32000,32003
resection, small 30565,30566
sling procedure prior to radiotherapy 32183
urinary conduit, revision 36609
urinary reservoir, continent, formation 36606
Intra-abdominal artery/vein, cannulation, chemotherapy 34521
malignancy, radical or debulking operation 30392
Intra-anal abscess, drainage of 32174,32175
Intra-aortic balloon, counterpulsation, management 13847,13848
balloon pump, insertion of 38362,38609
balloon pump, removal of 38612,38613
Intra-arterial cannulisation for blood collection 13842
infusion chemotherapy 13927,13930,13933
13936
infusion, of sympatholytic agent 14209
Intra-atrial baffle, insertion of 38745
Intra-epithelial neoplasia, laser therapy for 35539,35542,35545
Intra-ocular excision of dermoid of eye 42574
foreign body, removal of 42560,42563,42566
42569
procedures, resuturing of wound after 42857
Intra-operative ultrasound, biliary tract 30439
staging of intra-abdominal tumours 30441
Intra-oral tumour, radical excision of 30275
Intra-orbital abscess, drainage of 42572
Intracerebral tumour, craniotomy and removal of 39709
Intracranial abscess, excision of 39903
aneurysm, clipping or reinforcement of sac 39800
aneurysm, endovascular coiling 35412
aneurysm, ligation of cervical vessel/s 39812
arteriovenous malformation, excision of 39803
cyst, drainage of via burr-hole 39703
electrode placement 40709,40712
haemorrhage, burr-hole craniotomy for 39600,39603
infection, drainage of via burr-hole 39900
neurectomy, for trigeminal neuralgia 39106
pressure monitoring device, insertion of 39015
pressure monitoring, catheter/subarachnoid bolt 13830
stereotactic procedures 40800,40803
tumour, biopsy and/or decompression 39706
tumour, burr-hole biopsy for 39703,39706
tumour, craniotomy and removal of 39709,39712
Intradiscal injection of chymopapain 40336
Intradural lesion, laminectomy for, not otherwise
covered 40312
Intrahepatic bypass 30466,30467
Intramedullary tumour, laminectomy and radical excision 40318
Intranasal operation on antrum/removal offoreign body 41716
operation on frontal sinus or ethmoid sinuses 41737
operation on sphenoidal sinus 41752
Intrascleral ball or cartilage, insertion of 42515
Intrathecal infusion device, revision of 39133
steroid injection 18232
Intrathoracic operation on heart, lungs, etc, other 38456
vessels, anastomosis/repair 38727,38730
Intrauterine contraceptive device, introduction of 35503
contraceptive device, removal of under GA 35506
device, introduction of, for idiopathic menorrhagia 35502
growth retardation, attendance for 16508
Intravascular injections
pressure monitoring 13876
Intravenous infusion chemotherapy 13915,13918,13921
13924
perfusion of a sympatholytic agent 14209
regional anaesthesia of limb 18213
Intraventricular baffle, insertion of 38754
Intubation, small bowel 30487,30488
Intussusception, reduction of 30375
management fluid/gas reduction for 14212
paediatric, operations for 43933,43936
Invitro fertilisation 13200,13203,13206
13209,13212,13215,13218,13221
processing of bone marrow 13760
Ionisation, cervix 35608
Iridectomy 42764
and sclerectomy, for glaucoma (Lagrange's op) 42746
following intraocular procedures 42857
Iridencleisis 42746
Iridocyclectomy 42767
Iridotomy 42764
laser 42785,42786
Iris and ciliary body, excision of tumour of 42767
excision of tumour of 42764
tumour, laser photocoagulation of 42806
Ischaemic limb, debridement of deep tissue 35100
limb, debridement of superficial tissue 35103
ventricular septal rupture, repair of 38509
Ischio-rectal abscess, drainage of 32174,32175
abscess, incision with drainage 30223

J

Jacket, plaster, application of, to spine 47708
Jaw, dislocation, treatment of 47000
aspiration biopsy of cyst/s 45799
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512,45815
reconstruction operation 45596,45597,45599
45602,45605,45608,45611
Jejunal atresia, bowel resection and anastomosis 43810
extension, percutaneous gastrostomy tube 31460
Jejunostomy, operative feeding 31462
Joint, application of external fixator, not for
fracture 50130
arthrodesis of 50109
arthroplasty of, not otherwise covered 50127
arthroscopy of 50100

arthrotomy of 50103
cicatricial flexion contracture of, correction 50112
deformity, correction of 50300
dislocation, treatment of 47024,47027,47030
47033,47036,47039,47042,47045
finger/hand, debridement of 46336
greater trochanter, transplantation of 50121
manipulation of 50115
sacro-iliac, arthrodesis 49300
sacro-iliac, disruption of 47513
stabilisation, repair capsule/ligament 50106
subtalar, arthrodesis of 50118
synovectomy of, not otherwise covered 50104
Juvenile cataract, removal of 42716

K

Keloid, excision of
extensive, multiple injections of hydrocortisone 30210
Keratectomy, partial, for corneal scars 42647
phototherapeutic 42810
Keratocanthoma, removal of31255-31258,31260-31263,31265-31268
31270-31273,31275-31278,31280-31283,31285-31288
31290-31293,31295
Keratoplasty 42653,42656,42659
Keratosis, obturans, surgical removal 41509
Kidney, dialysis, in hospital 13100,13103
donor, continuous perfusion of 22055
exploration of 36537
ruptured, exposure and exploration of 36576
solitary, pyeloplasty by open exposure 36567
transplant 36503,36506,36509
Kirschner wire, insertion of 47921
Knee, amputation at or below 44367
arthrodesis of 49512,49545
arthroplasty of 49518,49519,49521
49524,49527,49530,49533,49534
arthroscopy of 49557-49564,49566
arthrotomy of 49500
collateral or cruciate ligament repair 49503,49506
congenital deformity, post-op manipulation, plaster 50348
contracture of, posterior release 50363,50366,50369
50372
cruciate ligament reconstruction 49536,49539,49542
dislocation, treatment of 47054
fracture, treatment of 47588,47591
hamstring tendon transfer 50357,50360
hemiarthroplasty of 49517
ligament or tendon transfer 49503,49506
meniscectomy of 49503,49506
mobilisation, for post-traumatic stiffness 49569
orthopaedic treatment of 49503,49506
patello-femoral stabilisation 49503,49506,49564
patello-femoral stabilisation, revision of 49548
prosthesis, removal of 49515
reconstruction/repair 49536,49539
rectus femoris tendon transfer 50357
replacement procedures 49518,49519,49521
49524,49527,49530,49533,49534
revision of orthopaedic procedures 49551,49554
synovectomy of 49509
Kyphosis, treatment of 48606,48613
treatment of including paediatric 50600,50604,50608
50612,50616,50620,50624,50628,50632

L

Labioplasty, where medically indicated 35533
Labour, second trimester, management of 16525
Labyrinth, destruction of 41572
Labyrinthotomy 41572
Laceration, ear/eyelid/nose/lip, full thickness, repair 30052
repair and suturing of 30026,30029,30032
30035,30038,30041,30042,30045,30048,30049
Lacrimal canalicular system, establishment patency 42599,42602
canaliculus, immediate repair of 42605
drainage by insertion of glass tube 42608
gland, excision of palpebral lobe 42593
passages, obstruction, probing for 42610,42611,42614
42615
sac, excision of 42596
Lagrange's operation (iridectomy and sclerectomy) 42746
Laminectomy and insertion of epidural implant 39139
followed by posterior fusion 40324,40327
for cordotomy or myelotomy 39124
for extradural tumour or abscess 40309
for hydromelia 40342
for intradural lesion 40312
for recurrent disc lesion and/or spinal stenosis 40303
for removal of intervertebral disc/s 40300
for spinal stenosis 40303,40306
with bone graft and posterior fusion 48654,48657
with excision of arteriovenous malformation 40318
with excision of intra-medullary tumour 40318
Laparascopic division of adhesions 31450,31452,35637
splenectomy 31470
Laparoscopy and hysteroscopy under GA 35636
complicated operative 35638,35641
diagnostic 30390
division of adhesions 30393,35637
involving procedures via laparoscope 35637,35638
laparoscopically assisted hysterectomy 35750,35753,35754
35756
on abdominal viscera 30375
sterilisation via 35687,35688
with biopsy 30391
with drainage of pus 31454
with transection/resection Fallopian tubes 35687,35688
Laparostomy 30397,30399
Laparotomy and division of adhesions 30376,30378,30379
exploratory 30373
for control of post-operative haemorrhage 30385,33845
for drainage 30394
for grading of lymphoma 30384
for gross intra-peritoneal sepsis 30396
for intussusception, paediatric 43933,43936
for neonatal conditions 43801,43804,43807
43810,43813,43816,43819,43822,43825,43828,43831
for staging of gynaecological malignancy 35726
for thrombosis 33845
for trauma, involving 3 or more organs 30388
involving gynaecology (exc. hysterectomy) 35712,35713,35716
35717
on abdominal viscera 30375,30387
with division of extensive adhesions 30379
with insertion of portacath 30400
Large intestine, resection of 32000,32003
intestine, subtotal colectomy 32004,32005
Laryngeal web, division of 41868
Laryngectomy 41834
supraglottic 41840
Laryngofissure, external operation on 41876
Laryngopharyngectomy 41843
- or primary restoration of alimentary continuity
after 41843
- with tracheostomy and plastic reconstruction 30294
Laryngoplasty 41876,41879
Laryngoscopy 41846,41849,41852
fibreoptic, with examination of larynx 41764
Larynx, direct examination of 41846
direct examination of, with biopsy 41849
direct examination of, with removal of tumour 41852

external operation on 41876
fibreoptic examination of 41764
fractured, operation for 41873
Laser: ablation of prostate, endoscopic 37207,37208
angioplasty, peripheral 35315
capsulotomy 42788,42789
coagulation corneal/scleral vessels 42797
destruction of bladder tumour with cystoscopy 36840,36845
destruction of stone with urethroscopy 37318
diathermy/visual laser for lesion of prostate 37224
division of suture, eye 42794
excision, tumours of face/neck 30190
incision of palate 41787
iridotomy 42785,42786
photocoagulation of iris tumour 42806
photocoagulation of neoplastic skin lesions 30195
photocoagulation of vascular lesions 14100,14106,14109 14112,14115,14118,14124
photoiridosyneresis 42808
photomydriasis 42807
removal of cancer of skin/mucous membrane 30196
removal of palmar/plantar warts 30187
resurfacing, carbon dioxide, face or neck 45025,45026
therapy for intraepithelial neoplasia 35539,35542,35545
therapy for malignancy of gastrointestinal tract 30479
trabeculoplasty 42782,42783
treatment, eye 42782,42783,42785 42786,42788,42789,42791,42792,42794,42797,42801 42802,42805,42806
vitreolysis/corticolysis 42791,42792
Lateral pharyngeal bands, removal of 41804
pharyngotomy 41779
rhinotomy with removal of tumour 41728
Lavage and proof puncture of maxillary antrum 41698,41701
colonic, total, intra-operative 32186
gastric, in the treatment of ingested poison 14200
maxillary antrum 41704
Le Fort osteotomies 45753,45754
operation for genital prolapse 35578
Leg, amputation 44367,44370
hamstring tendon transfer 50357,50360
rectus femoris tendon transfer 50357
Lens, artificial, insertion of 42701,42703
artificial, removal and replacement 42707,42710
artificial, removal or repositioning 42704
extraction 42698
extraction and insertion of artificial lens 42702
intraocular, repositioning of 42713
Lensectomy 42731
Lesion, craniocervical junction, transoral approach for 40315
intradural, laminectomy for, not otherwise covered 40312
Lesions, skin, multiple injections for 30207
Leveen shunt, insertion of 30408
Lid, ophthalmic, suturing of 42584
scleral graft to 42860
Ligament, finger joint, repair of 46333
of foot, repair of 49812
or tendon transfer 47966
ruptured medial palpebral, repair of 42854
transplantation 47966
Ligation, great vessel 34103
purse string, cervix 16511
rubber band, of haemorrhoids or rectal prolapse 32135
transantral, of maxillary artery 41707
Ligature of cervix, purse string, removal of 16512
Limb, fasciotomy of 30226
ischaemic, debridement of tissue 35100,35103
lengthening procedures 50303,50306
lower, congenital deficiency, treatment of 50411,50414,50417
or chest, decompression escharotomy 45054
perfusion of 22055,34533
Limbic tumour, removal or excision of 42692,42695
Linea alba hernia, repair of, under 10 years 30616,30617
alba hernia, repair of, over 10 years 30620,30621
Lingual tonsil, removal of 41804
Lip, cleft, operations for 45677,45680,45683 45686,45689,45692,45695,45698,45701,45704
full thickness laceration, repair 30052
full thickness wedge excision 45665
reconstruction 45671,45674
Lipectomy, radical abdominoplasty 30177
subumbilical excision 30174
wedge excision 30165,30168,30171
Lipomeningocoele, tethered cord, release of 40112
Liposuction, for post-traumatic pseudolipoma 45584,45585
abdominal contouring post diabetic injections 31346
for reduction of a buffalo hump 45586
free tissue transfer, complete revision of 45497
free tissue transfer, first stage revision of 45498
free tissue transfer, second stage revision 45499
Lippe's loop, introduction of 35503
loop, removal of under GA 35506
Lisfranc's amputation 44364
Litholapaxy, with or without cystoscopy 36863
Lithotripsy, extracorporeal shock wave (ESWL) 36546
Little's Area, cautery of 41674
Liver abscess, open abdominal drainage of 30431,30433
biopsy 30409,30411,30412
cyst/s, laparoscopic marsupialisation 30416,30417
hydatid cyst, removal of contents of 30434,30436
hydatid cyst, total excision of 30437,30438
lobectomy of, for trauma 30428,30430
lobectomy of, other than for trauma 30418,30421
repair of laceration/s, for trauma 30422,30425
ruptured, repair 30375
segmental resection of 30414,30415,30427
tumours destruction by radiofrequency ablation 50950,50952
tumours, destruction of by cryotherapy 30419
Living tissue, implantation of 14203,14206
Lobar emphysema, neonatal, thoracotomy & lung resection 43861
Lobectomy, liver, for trauma 30428,30430
liver, other than for trauma 30418,30421
lung 38438,38441
partial, for epilepsy 40703
superficial, of parotid gland 30253
Local anaesthetic, injection of
flap repair 45200,45203,45206
flap revision 45239,45240
Lop ear or similar deformity, correction of 45659
Lord's procedure, massive dilatation of anus 32153
Lumbar cerebrospinal fluid drain, insertion of 40018
decompression of spinal cord 40351
discectomy, percutaneous 48636
puncture 39000
shunt diversion, insertion of 40006
shunt, revision or removal of 40009
sympathectomy 35000,35009
Lunate bone, osteectomy or osteotomy of 48406
Lung compliance, estimation of
hydatid cysts, enucleation of 38424
intrathoracic operation, not otherwise covered 38456
needle biopsy of 38812
resection, congenital cystadenomatoid malformation 43861
resection, congenital lobar emphysema 43861
wedge resection of 38440
Lymph glands, axilla, excision of 30332,30335,30336
glands, biopsy of 30074,30075,30078
glands, groin, excision of 30329,30330
glands, pelvic, radical excision of 35551
node biopsies, retroperitoneal 35723
node dissection, retroperitoneal 37607,37610
node of neck, biopsy of 31420

nodes of axilla, excision of 30335,30336
nodes of neck, dissection of 31423,31426,31429 31432,31435,31438
sentinel node biopsy for breast cancer 30299,30300,30302 30303
Lymphadenectomy, atypical mycobacterial infection 44130
granulomatous disease 44130
pelvic 35551,36502
Lymphangiectasis, limbs, major excision 45048
Lymphangioma, excision of 45030,45033,45035 45036
Lymphoedema, major excision of 45048
Lymphoid patches, removal of 45801,45803,45805 45807,45809

M

Macrocheilia, operation for 45675
Macrodactyly, surgical reduction of enlarged elements 46510
Macroglossia, operation for 45675
Macrostomia, operation for 45676
Magnetic removal of intraocular foreign body 42560,42566
Malignant lesion, removal of 31300,31305,31310 31315,31320,31325,31330,31335
Malignant upper aerodigestive tract tumour 31400,31403,31406
Mallet finger, closed pin fixation of 46438
finger, open repair of text test 46441
finger, with intra-articular fracture, open reduction 46442
Mammaplasty, augmentation 45524,45527,45528
reduction 45520,45522
Mammary prosthesis, removal of 45548,45551,45552
prosthesis, replacement of 45552-45554
Manchester operation for genital prolapse 35577
Mandible, condylectomy 45611
dislocations, treatment of 47000
hemi-mandibular reconstruction with bone graft 45608
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512,45815
or maxilla, fractures, treatment of 47753,47756,47762 47765,47768,47771,47774,47777,47780,47783,47786 47789
osteectomy or osteotomy of 45720,45723,45726 45729,45731,45732,45735,45738,45741,45744,45747 45752
resection of 45599,45602,45605
segmental resection of, for tumours 45605
Mandibular, frenulum, repair of, under GA 30281
or palatal exostosis, excision of 45825
Manipulation of fibrous tissue surrounding breast prosthesis
of joints 50115
of spine 48600,48603
of ureteric calculus, endoscopic 36857
Manometry, biliary 30493
Marshall-Marchetti operation for urethropexy 35599,37044
Marsupialisation of Bartholin's cyst or gland 35516,35517
salivary gland 30265,30266
Mastectomy, total 31518,31521
subcutaneous 31524,31527
Mastitis, granulomatous, exploration and drainage 31551
Mastoid cavity, obliteration of 41548,41564
portion, decompression of facial nerve 41569
Mastoidectomy, cortical 41545
intact wall technique, with myringoplasty 41551,41554
radical or modified radical 41557,41560,41563 41564
revision of, with myringoplasty 41566
with insertion of cochlear implant 41617
with transmastoid removal of glomus tumour 41623
Maxilla, operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512,45815
or mandible, fractures, treatment of 47753,47756,47762 47765,47768,47771,47774,47777,47780,47783,47786 47789
osteectomy or osteotomy 45720,45723,45726 45729,45731,45732,45735,45738,45741,45744,45747 45752
resection of, segmental, for tumour/cyst 45605
resection of, sub-total 45602
resection of, total 45596,45597
Maxillary antrum, lavage of 41704
antrum, proof puncture and lavage of 41698,41701
artery, transantral ligation of 41707
frenulum, repair of 30281
sinus lift procedure 45849
sinus, drainage of, through tooth socket 41719
sinus, operations on 41710,41713,41716 41719,41722
tuberosity, reduction of 45829
Meatoplasty, with correction of auditory canal stenosis 41521
with removal of cartilage and/or bone 41512,41515
Meatotomy and hemi-circumcision, hypospadias 37354
ureteric, with cystoscopy 30265,30266,36830
urethral 37321
Meatus, external auditory, removal of exostoses in 41518
external auditory, removal of keratosis obturans 41509
internal auditory, exploration of 41599
pinhole urinary, dilatation of 37300
Meckel's diverticulum, removal of 30375
Meconium ileus, laparotomy for 43813,43816
Medial palpebral ligament, ruptured, repair of 42854
Median bar, endoscopic resection of 36854
sternotomy for post-operative bleeding 38656
Mediastinum, cervical exploration of 38448
exploration of, for hyperparathyroidism 30318,30320
intrathoracic operation on, not otherwise covered 38456
Meibomian cyst, extirpation of 42575
Melanoma, removal of 31300,31305,31310 31315,31320,31325,31330,31335
excision of, oral & maxillofacial region 45801,45803,45805 45807,45809
Melasma, full face chemical peel 45019,45020
Meloplasty, for correction of facial asymmetry 45587,45588
Membranes, retained, evacuation of 16564
Meningeal haemorrhage, operations for 39600,39603
Meningocele, excision and closure of 40100
Meniscectomy, knee 49503,49506
temporo-mandibular 45755
Mesenteric artery, inferior, operation on 32736
vessels, by-pass grafting to 32730,32733
Meso caval shunt for portal hypertension 30603
Metacarpal bones, amputation of 44325
bones, bone grafting, pseudarthrosis 46402,46405
bones, fracture, treatment of 47336,47339,47342 47345
bones, operation for osteomyelitis 46462
bones, osteotomy/osteectomy 46396,46399
Metacarpophalangeal joint, arthrodesis 46300
joint, arthroplasty 46306,46307,46309 46312,46315,46318,46321
joint, arthrotomy 46327,46330
joint, dislocation, treatment of 47042,47045
joint, hemiarthroplasty 46309,46312,46315 46318,46321
joint, ligamentous repair of 46333
joint, volar plate arthroplasty 46307
Metacarpus, operation on, for chronic osteomyelitis 43512
Metastatic carcinoma, craniotomy for removal of 39709
Metatarsal bones, osteotomy or osteectomy of 48400,48403
fracture, treatment of 47633,47636,47639 47642,47645,47648,47651,47654,47657
Metatarso-phalangeal joint, synovectomy of 49860,49863

joint, total replacement of 49857
Metatarsus, amputation or disarticulation of 44358
operation on, for acute osteomyelitis 43500
Micro-arterial graft 45503
Microdochotomy of breast, benign or malignant condition 31554
Microlaryngoscopy 41855
- with arytenoidectomy 41867
- with division of laryngeal web 41868
- with removal of juvenile papillomata 41858
- with removal of papillomata by laser surgery 41861
- with removal of tumour 41864
Microsomia, construction of condyle and ramus 45791
Microvascular anastomosis using microsurgical techniques 45502
for supercharging of pedicled flaps 45561
repair using microsurgical techniques 45500,45501,45504
Microvenous graft 45503
Middle ear, clearance of 41635,41638
ear, exploration of 41629
ear, insertion of tube for drainage of 41632
ear, operation for abscess or inflammation of 41626
palmar spaces of hand, drainage of 46519
Midtarsal amputation of foot 44364
Miles' operation 32039
Minitracheostomy insertion 41884
Minnesota tube, insertion of 13506
Miscarriage, habitual, treatment of 16504
incomplete, curettage for 35639,35640
threatened, ligation of cervix 16511
threatened, treatment of 16505
Mitral annulus, reconstruction after decalcification 38485
valve, open valvotomy of 38487
Mitrofanoff continent valve, formation of 37045
Moh's procedure 31000-31002
Mole, desiccation by diathermy
retained, evacuation of 16564
Molluscum contagiosum, removal in operating theatre 30189
Morbid obesity, operations for 30511,30512,30514
Mucous membrane, biopsy of 30071
membrane, cancer, treatment 30196,30197,30202 30203,30205
membrane, graft 42641
membrane, repair of recent wound 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
Multiple delivery, administration of anaesthetic
Multiple, injections for varicose veins 32500,32501
pregnancy, interventional techniques 16633,16636
Muscle, activity sampling (electromyography)
biopsy of 30074,30075
distal, devascularisation of 32200
excision of 30226,30229
excision of, with melanoma 31340
extra-ocular, ruptured, repair of 42854
flap repair 45000,45009,45012
flap, delay of 45015
removal of foreign body from 30067,30068
ruptured, repair of 30232,30235
transfer for facial nerve paralysis 45578
transplant (Hummelsheim type), for squint 42848
Myelomeningocele, excision and closure of 40103
Myelotomy, laminectomy for 39124
Mylohyloid ridge, reduction of 45827
Myocardial electrode, permanent, insertion, thoracotomy 38470
biopsy, by cardiac catherterisation 38275
Myocutaneous flap, delay of 45015
flap repair 45003,45006
Myoma, hysteroscopic resection 35623
Myomectomy, hypertrophic obstructive cardiomyopathy 38650
uterine, abdominal 35649
uterine, laparoscopic 35638
Myotomy, cricopharyngeal 41770,41776
hypertrophic obstructive cardiomyopathy 38650
ocular muscles 42833,42839,42851
oesophagogastric (Heller's operation) 30532,30533
Myringoplasty 41527,41530
- and mastoidectomy 41551,41560
- and ossicular chain reconstruction 41542
- and revision of mastoidectomy 41566
- with mastoidectomy and ossicular chain recon 41554,41563
Myringotomy 41626

N

Naevus, excision of
excision of, in oral & maxillofacial region 45801,45803,45805 45807,45809
Nail bed, exploration and repair of deformity 46489
bed, reconstruction of laceration 46486
digital, of finger or thumb, removal of 46513,46516
digital, of toe, removal of 47904,47906
ingrowing, of finger or thumb, resection 46528,46531
ingrowing, of toe, excision/resection 47915,47916,47918
ingrown, of toe, operation under GA, paediatric 44136
plate injury/deformity, radical excision 46534
plate or rod, removal of 47930
Nasal adhesions, division of 41683
bones, fracture, treatment of 47735,47738,47741
cavity and/or post nasal space, examination of 41653
cavity, packing for arrest of haemorrhage 41677
haemorrhage, arrest of 41656,41677
haemorrhage, cryotherapy in the treatment of 41680
polyp or polypi, removal of 41662,41665,41668
septum button, insertion of 41907
septum, reconstruction of 41672
septum, septoplasty or submucous resection 41671
space, post, direct examination of 41761
turbinates, cryotherapy 41695
Nasendoscopy 41764
Naso-lacrimal tube, replacement of 42610,42611,42614 42615
Nasopharyngeal angiofibroma, transpalatal removal 41767
Nasopharynx, fibreoptic examination of 41764
Neck, deep-seated haemangioma, excision of 45036
excision of infected by-pass graft 34157
scar, revision of (restriction applies) 45506,45512
Necrosectomy, pancreatic 30577
Necrotic material, debridement of 35100,35103
Needle biopsy, aspiration
biopsy of prostate 37218
biopsy of vertebra 30093
Needling of cataract 42734
needling of encysted bleb 42744
Neonatal alimentary obstruction, laparotomy for 43825
surgery 43801,43804,43807 43810,43813,43816,43819,43822
neonatal, repair of 30387
Neoplasia, intraepithelial, laser therapy 35539,35542,35545
Neoplastic lesions, cutaneous, treatment of 30195
Nephrectomy 36516,36519,36522 36525-36529
radical, for nephroblastoma, paediatric 43984
Nephro-ureterectomy, complete, with bladder repair 36531
for tumour 36532
for tumour, complicated 36533
Nephroblastoma, operations for 43981,43984
Nephrolithotomy 36540,36543
Nephroscopy 36627,36630,36633 36636,36639,36642,36645,36648
Nephrostomy 36552
drainage tube, exchange of, imaging guided 36649
percutaneous, using interventional imaging 36624
Nerve block, regional or field 18213,18216,18219

18222,18225-18228,18230,18232-18234,18236,18238
18240,18242,18244,18246,18248,18250,18252,18254
18256,18258,18260,18262,18264,18266,18268,18270
18272,18274,18276,18278,18280,18282,18284,18286
18288,18290,18292,18294,18296,18298
cranial, intracranial decompression 39112
cutaneous, nerve graft to 39318
cutaneous, repair of 39300,39303
exploration of 39330
facio-hypoglossal or facio-accessory, anastomosis of 39503
graft to nerve trunk 39315
intracranial, for trigeminal neuralgia 39106
peripheral, removal of tumour from 39324,39327
sacral, stimulation for faecal incontinence 32213-32218
section, retrolabyrinthine, vestibular/cochlear 41596
section, translabyrinthine, vestibular 41593
stimulation for pain 39130,39131,39133-39139
transposition of 39321
trigeminal, primary branch, injection with alcohol etc 39100
trunk, internal (interfasicular), neurolysis of 39312
trunk, microsurgical repair 39306,39309
trunk, nerve graft to 39315
vestibular, section of, via posterior fossa 39500
Neurectomy, foot, for plantar digital neuritis 49866
intracranial, for trigeminal neuralgia 39106
peripheral nerve 39324,39327
transantral vidian, with antrostomy 41713
Neuroblastoma, operations for 43981,43984,43987
Neuroendocrine tumour, retroperitoneal, removal of 30321,30323
Neuroendoscopy 40903
Neurolysis, by open operation 39330
of nerve trunk 39312
Neuroma, acoustic, removal of 41575,41576,41578
41579
Neurostimulator receiver, spinal, subcutaneous
placement 39134
Neurotomy, of peripheral nerves 39327
percutaneous, for facet joint denervation 39118
percutaneous, of spinal nerves 39115
Neurovascular island flap, for pulp innervation 46504
island flap, with vascular pedicle 45563
Nipple, accessory, excision of 31566
inverted, surgical eversion of 31563
reconstruction of 45545,45546
Noble type intestinal plication with enterolysis 30375
Node, lymph, biopsy of 30074,30075
scalene, biopsy 30096
Nodes, lymph, pelvic, excision of 35551
Non-gravid uterus, suction curettage of 35639,35640
Nose, cauterisation or packing, for haemorrhage 41677
composite graft to 45656
cryotherapy to, for haemorrhage 41680
dermoid of, congenital, excision of 41729
foreign body in, removal of, other than simple 41659
fracture, treatment of 47735,47738,47741
full thickness repair of laceration (restriction) 30052
operations, other 41659,41662,41665
41668,41671,41672,41674,41677,41680,41683,41686
41689,41692,41695
plastic operations 45632,45635,45638
45639,45641,45644-45647,45650,45652,45653

O

Obesity, morbid, surgical reversal of gastric procedure 30514
Ocular muscle, torn, repair of 42854
transillumuination 42821
Odontoid screw fixation 40316
Oesophageal atresia, neonatal, operations for 43843,43846,43849
43852,43855,43858
atresia/corrosive stricture, replacement for 43903
perforation, repair of, by thoracotomy 30560
prosthesis, insertion of 30490
stricture, endoscopic dilatation of 41819,41820
transection for portal hypertension 30606
tube, indwelling, gastrostomy for fixation 30375
Oesophagectomy 30535,30536,30538
30539,30541,30542,30544,30545,30547,30548,30550
30551,30553,30554,30556,30557
cervical 30294
Oesophagogastric myotomy 30532,30533
Oesophagoscopy 30473,30475,30476
30478
with dilatation of stricture 41819,41820
with rigid oesophagoscope 41816,41822,41825
Oesophagostomy, cervical 30293,30294
cervical, neonatal oesophageal atresia 43858
closure or plastic repair of 30293
Oesophagus, resection of stricture, paediatric 43906
balloon dilatation of 41832
dilatation of 41819,41820,41822
41825,41828,41831
intrathoracic operation on, not otherwise covered 38456
local excision for tumour 30559
removal of foreign body in 41825
Olecranon, excision of bursa of 30110,30111
fracture, treatment of 47396,47399,47402
fracture, treatment of paediatric 50540
Omentectomy, infra-colic 35726
with debulking operation 35720
Oophorectomy, laparoscopic 35638
with laparotomy, not with hysterectomy 35712,35713,35716
35717
with vaginal hysterectomy 35673
Open heart surgery, not otherwise covered 38653
Operative arteriography or venography 35200
cholangiography or pancreatography 30439
feeding jejunostomy 31462
laparoscopy, complicated 35641
Ophthalmological examination under GA 42503
Optic fundi, examination of
nerve meninges, incision of 42548
Orbit, anophthalmic, insertion of cartilage or implant 42518
anophthalmic, placement of motility integrating peg 42518
eye, decompression of 42545
eye, exenteration of 42536
eye, exploration of 42530,42533
eye, removal tumour/foreign body 42539,42542,42543
eye, skin graft to 42524
Orbital cavity, bone or cartilage graft to 45593
cavity, reconstruction of 45590
dermoid, congenital, excision of 42574
dystopia, correction of 45776,45779
implant, enucleation of eye 42506,42509
implant, evisceration of eye and insertion of 42515
Orbitotomy 42530,42533
Orchidectomy 30638,30641
Orchidopexy for undescended testis 37803,37806,37809
Oro-antral fistula, plastic closure of 41722
pin or wire, insertion of 47921
Oro-nasal fistula, plastic closure of 45714
Orthopaedic pin or wire, insertion of 47921
ring fixator, adjustment of 50309
Osseo-integration procedures 45794,45797,45847
for implantable bone conduction hearing system 41603,41604
Ossicular chain reconstruction 41539,41542
Osteectomy of accessory bone 48400
carpus 48406,48409
clavicle 48406,48409
femur 48424,48427
fibula 48406,48409
humerus 48412,48415

mandible or maxilla 45720,45723,45726
45729,45731,45732,45735,45738,45741,45744,45747
45752
metatarsal 48400,48403
pelvic bone 48424
pelvis 48427
phalanx 48400,48403
radius 48406
rib 48406
scapula (other than acromion) 48406
sesamoid bone 48400
tarsus 48406
tibia 48418,48421
ulna 48406
Osteomyelitis, acute or chronic, operations for 43500,43503,43506
43509,43512,43515,43518,43521,43524
carpus, operation for 46462
metacarpal, operation for 46462
operations for, in oral and maxillofacial region 45815,45817
phalanx, operation for 46459,46462
skull, craniectomy for 39906
Osteoplasty of knee 49503,49506
Osteotomy of accessory bone 48400
carpus 48406,48409
clavicle 48406,48409
femur 48424,48427
fibula 48406,48409
foot 49833,49836-49838
humerus 48412,48415
mandible or maxilla 45720,45723,45726
45729,45731,45732,45735,45738,45741,45744,45747
45752
metatarsal 48400,48403
midfacial 45753,45754
pelvic bone 48424
pelvis 48427
phalanx 48400,48403
radius 48406,48409
rib 48406,48409
scapula (other than acromion) 48406,48409
sesamoid bone 48400
tarsus 48406,48409
tibia 48418,48421
ulna 48406,48409
Otitis media, acute, operation for 41626
Oval window surgery 41615
Ovarian biopsy by laparoscopy 35637
cyst aspiration 35518
cyst, excision of, with hysterectomy 35673
cyst, excision of, with laparotomy 35712,35713,35716
35717
cyst, puncture of, via laparoscope 35637
cystectomy, laparoscopic 35638
transposition with hysterectomy for malignancy 35729
tumour, radical or debulking operation for 35720
ovaries, operation for 30387
rectum, abdominal rectopexy 32117
rectum, perineal repair of 32120
rectum, rubber band ligation of 32135
rectum, sclerotherapy for 32132
urethra 35570,35573
urethra, excision of 37369
vaginal, repair of 35568-35573,35577,35578
35595-35597
Ovaries, prolapse, operation for 30387
Oxycephaly, cranial vault reconstruction for 45785
Oxygen consumption, estimation of
therapy, hyperbaric 13020,13025,13030

P

Pacemaker electrode, permanent, insertion, sub-xyphoid 38473
gracilis neosphincter 32210
permanent, insertion or replacement 38353
Pacemaking electrode, temporary transvenous, insertion 38256
Pain management, implanted drug delivery system39125-39128,39130,39131
39133
spinal and peripheral nerve stimulation39130,39131,39133-39139
Palatal exostosis, excision of 45825
Palate, cleft, repair of 45707,45710,45713
papillary hyperplasia removal of 45831,45833,45835
Palmar warts, removal of 30185-30187
Palpebral ligament, medial, ruptured, repair of 42854
lobe of lacrimal gland, excision of 42593
Pancreas, drainage of 30375
excision of 30583
Pancreatectomy 30583,30593,30594
Pancreatic abscess, laparotomy and external drainage of 30575
cyst, anastomosis to Roux loop of jejunum 30587
cyst, anastomosis to stomach or duodenum 30586
juice, collection of 30488
necrosectomy 30577
Pancreatico-duodenectomy (Whipple's operation) 30584
Pancreatico-jejunostomy 30589,30590
Pancreato-cholangiography, endoscopic 30484
Pancreatography, operative 30439
Panendoscopy 30473,30476,30478
Panhysterectomy 35664
Pannus, treatment of, with cautery of conjunctiva 42677
Papilloma, bladder, transurethral resection 36840,36845
larynx, removal of 41852
removal in oral & maxillofacial region 45801,45803,45805
45807,45809
Papillomata, juvenile, removal with microlaryngoscopy 41858
removal of by laser surgery 41861
Para-oesophageal, hiatus hernia, repair of 31468
Paracentesis abdominis 30406
anterior or posterior chamber or both 42740
in relation to eye 42734
of tympanum 41626
thoracic cavity 38803
Paralysis, facial nerve, plastic operations for 45575,45578
Parapharyngeal tumour, excision of 31409,31412
Paraphimosis, reduction of under GA 30666
Parathyroid operation for hyperparathyroidism 30315
Parental nutrition
central vein, tunnelled cuffed catheter 34538
removal of tunnelled cuffed catheter 34539
Paretic states, eyebrows, elevation of 42872
Parks' intersphincteric operation 32126
Paronychia of foot, incision for 47912
of hand, incision for 46525
Parotid duct, diathermy or dilatation 30262
duct, meatotomy or marsupialisation 30265,30266
duct, removal of calculus 30265,30266
duct, repair of, 30246
fistula, repair of 30269
gland, superficial lobectomy/removal of tumour 30253
gland, total extirpation of 30247,30250
tumour, excision of 30251
Parovarian cyst, removal of 35712,35713,35716
35717
Patch angioplasty for vein stenosis 34815
grafting to artery or vein 33545,33548
Patella, bursa, excision of 30110,30111
congenital dislocation, reconstruction of quadriceps 50420
dislocation, treatment of 47057,47060
fracture, treatment of 47579,47582,47585
Patellar bursa, excision of 30110,30111
Patellectomy 49503,49506
Patello-femoral stabilisation 49503,49506,49564
stabilisation, revision of 49548

Patent diseased coronary bypass vein graft, dissection 38637
ductus arteriosus, division/ligation 38700,38703
urachus, excision of 37800
Pectus carinatum, repair or radical correction 38457
excavatum, repair or radical correction 38457,38458
Pedicle, tubed, or indirect flap 45230
- formation of 45227
- preparation of site and attachment to site 45233
- spreading of pedicle 45236
Pelvi-ureteric junction, plastic procedures to 36564
cystoscopy of 36825
Pelvic abscess, drainage via rectum or vagina 30223
abscess, laparotomy for drainage of 30394
bone, operation on, for osteomyelitis 43509,43518
bone, osteectomy or osteotomy of 48424,48427
floor repair, laparoscopic or abdominal 35595
haematoma, drainage of 30387
lymph glands, excision of 35551,35664,35670
ring, fracture, treatment of 47474,47477,47480
47483,47486,47489
Pelvic lymphadenectomy 36502
Pelvis, bone graft/shelf procedure, acetabular
dysplasia 50393
fracture, treatment of 47474,47477,47480
47483,47486,47489,47492,47495,47498,47501,47504
47507,47510
osteotomy or osteectomy of 48424,48427
Penile warts, cystoscopy for treatment of 36815
Penis, amputation of 37402,37405
artificial erection device, insertion 37426,37429
artificial erection device, revision or removal of 37432
circumcision of 30653,30656,30659
30660
correction of chordee 37417,37418
frenuloplasty 37435
injection for impotence 37415
lengthening by translocation of corpora 37423
paraphimosis, reduction of under GA 30666
partial amputation of 37402
repair of avulsion 37411
repair of laceration of cavernous tissue, or fracture 37408
surgery for penile drainage causing impotence 37420
Peptic ulcer, bleeding, control of 30505,30506,30508
30509
ulcer, perforated, suture of 30375
Per anal release, rectal stricture 32114
Percutaneous aspiration biopsy of deep organ 30094
biliary dilatation 30495
biliary drainage 30440,30451,30495
biliary stenting 30492
cordotomy 39121
drainage of deep abscess, imaging guided 30224
endoscopic gastrostomy 30481,30482
epidural electrode, insertion 39130
epidural electrodes, management of 39131
epidural implant, removal 39136
gastrostomy tube, jejunal extension 31460
liver biopsy 30409
lumbar discectomy 48636
needle biopsy of lung 38812
neurotomy for facet joint denervation 39118
neurotomy of peripheral nerves 39323
neurotomy of spinal nerves 39115
retrieval of foreign body 35360-35363
retrieval of inferior vena caval filter 35331
transhepatic cholangiogram, imaging guided 30440
ureteric stent exchange 36608
Perforated duodenal ulcer, suture of 30375
gastric ulcer, suture of 30375
peptic ulcer, suture of 30375
Perforating wound of eyeball, repair of 42551,42554,42557
Perfusion of donor kidney, continuous 22055
of limb or organ 22055
retrograde, cerebral (if performed) 22075
retrograde, intravenous, sympatholytic agent 14209
whole body 22060
Perianal abscess, drainage of 32174,32175
abscess, incision with drainage 30223
excision of rectal tumour 32103,32104,32106
thrombosis, incision of 32147
Pericardectomy 38447,38449
Pericardium, drainage of, sub-xyphoid 38452
drainage of, transthoracic 38450
Perineal anoplasty, ano-rectal malformation 43960
biopsy of prostate 37212
graciloplasty 32203,32209
graciloplasty, insert. stimulator & electrode 32209
prostatectomy 37200
recto-sigmoidectomy for rectal prolapse 32112
repair of rectocele 32131
repair, rectal prolapse 32120
Perineorrhaphy 35571
Perinephric abscess, drainage of 36537
area, exploration of 36537
Periorbital correction of Treacher Collins Syndrome 45773
dermoid, congenital, excision of 42573
Peripheral arterial atherectomy 35312
arterial catheterisation 35321
cannulation for cardiopulmonary bypass 38603
laser angioplasty 35315
nerve, neurectomy/neurotomy/tumour 39324,39327
peripheral nerve stimulation for pain 39131,39133-39137
venous catheterisation 35317,35319,35320
Peritomy, conjunctival 42632
Peritoneal adhesions, division, with laparotomy30376,30378,30379
biopsies, multiple, with infracolic omentectomy 35726
catheter, insertion and fixation of 13109
catheter, removal of 13110
dialysis 13112
Peritoneo venous (Leveen) shunt, insertion of 30408
Peritonitis, laparotomy for 30394
Peritonsillar abscess, incision of 41807
Periurethral injection for urinary incontinence 37339
Perthes, hips or knees, application of cast under GA 50390
Petro-clival and clival tumour, removal of 39653,39654,39656
Peyronie's plaque, operation for 37417
Phalanges, amputation/splitting, congenital
abnormalities 50396
Phalanx, bone grafting of, for pseudarthrosis 46402,46405
distal, for osteomyelitis 46459
finger or thumb, fractures, treatment of 47300,47303,47306
47309,47312,47315,47318,47321,47324,47327,47330
47333
middle or proximal, for osteomyelitis 46462
operation for acute osteomyelitis 43500
operation for chronic osteomyelitis 43512
osteectomy or osteotomy of 46399,48400,48403
toe, fracture, treatment of 47663,47666,47672
47678
Pharyngeal adhesions, division of 41758
bands or lingual tonsils, removal of 41804
cysts, removal of 41813
flap for velo-pharyngeal incompetence 45716
pouch, endoscopic resection (Dohlman's op) 41773
pouch, removal of 41770
Pharyngectomy, partial 41782,41785
Pharyngoplasty 45716
Pharyngotomy (lateral) 41779
Pharynx, cauterisation or diathermy 41674
removal of foreign body from 30061
Photocoagulation, laser, vascular lesions 14100,14106,14109
14112,14115,14118,14124

of xenon arc 42782,42783
Photoiridosyneresis, laser 42808
Photomydriasis, laser 42807
Phototherapeutic, keratectomy 42810
Pigeon chest, correction of 38457
Pilonidal cyst or sinus, excision of 30675,30676
sinus, injection of sclerosant fluid 30679
Pin, orthopaedic, insertion of 47921
wire or screw, buried, removal of 47924,47927
Pinealoma, craniotomy for removal of 39712
Pinguecula, removal of 42689
Pinhole urinary meatus, dilatation of 37300
Pirogoff's amputation of foot 44361
Pitanguy abdominoplasty 30177
Pituitary tumour, removal of 39715
Placement of catheters 38220,38222,38243
Placenta, retained, evacuation of 16564
Placentography, preparation for 36800
Plantar fasciotomy, radical 49854
warts, removal of 30186,30187
Plaster jacket, application of, to spine 47708
Plastic procedures to pelvi-ureteric junction 36564
reconstruction for bicornuate uterus 35680
reconstruction of lacrimal canaliculus 42602
repair, direct flap 45209,45212,45215
45218,45221,45224
repair, of cervical oesophagostomy 30293
repair, single stage, local flap 45200,45203,45206
repair, to enlarge vaginal orifice 35569
Plate, rod or nail, removal of 47930
Pleura, percutaneous biopsy of 30090
Pleural effusion 38803
Pleurectomy with thoracotomy 38424
pleurodesis 38436
pleurodesis 38424
Plexus, brachial, exploration of 39333
Plication, intestinal, with enterolysis, Noble type 30375
Pneumonectomy 38438,38441
Poison, ingested, gastric-lavage in the treatment of 14200
Polycythemia 13757
Polyhydramnios, attendance, not routine antenatal 16502
Polyp, anal, excision of 32142,32145
aural, removal of 41506,41509
cervix, removal of 35611
larynx, removal of 41852
nasal, removal of 41662,41665,41668
rectal, removal with sigmoidoscopy 32078,32081
uterus, removal of 35639,35640
Polypectomy, with hysteroscopy 35633
Popliteal artery, exploration of, for popliteal
entrapment 34145
vessel, ligation or exploration, other 34103
Porta hepatitis, radical resection for carcinoma 30461
Portacath, laparatomy with insertion of 30400
Portal hypertension, operations for 30602,30603,30605
30606
Porto caval shunt for portal hypertension 30602
Portoenterostomy for biliary atresia 43978
Posterior chamber, removal of silicone oil 42815
juxtasceral Depot injection 42741
sclerotomy 42734
spinal fusion 40321,40324,40327
vaginal compartment repair 35571,35573
Postero-lateral bone graft to spine 48648,48651
Postnasal space, examination under GA 41653
space, direct examination with/without biopsy 41761
Postnatal care 16564,16567,16570
16571,16573
Postoperative haemorrhage 30058
- control under GA, independent 30058
- laparotomy for control of 30385
- tonsils/adenoids, arrest, under GA 41796,41797
following gynaecological surgery, under GA 35759
Postpartum haemorrhage, treatment of 16567
Pre-auricular sinus, excision of 30104
Preeclampsia, treatment of 16509
Pregnancy, attendance for complication by 16508
- diabetes or anaemia 16502
- intrauterine growth retardation 16508
- threatened premature labour 16502,16508
multiple, attendance other than routine antenatal 16502
Premalignant skin lesions, treatment of 30192
Premature labour, attendances not routine antenatal 16502,16508
Prepuce, breakdown of adhesions of
operations on 30653,30656,30659
30660,30663,30666
Presacral and sacrococcygeal tumour, excision of 32036
sympathectomy 35012
Pressure monitoring, intracranial 13830
monitoring, intravascular 13876
Priapism, decompression of 37393
shunt operation for 37396
Primary repair of cutaneous nerve 39300
repair of extensor tendon of hand or wrist 46420
repair of flexor tendon of hand or wrist 46426,46432
repair of nerve trunk 39306
restoration of alimentary continuity 41843
Proctectomy, perineal 32047
Proctocolectomy with ileostomy 32015,32018,32021
Products of conception, retained, evacuation of 16564
Progesterone implant 14203,14206
Proof puncture of maxillary antrum 41698,41701
Prostate, biopsy of 37212,37215,37218
37219
diathermy or visual laser destruction of 37224
endoscopic laser ablation 37207,37208
high energy transurethral microwave thermotherapy37230,37233
total excision of 37209-37211
transurethral microwave thermotherapy 37230,37233
Prostate, impantation of gold fiducial markers 37217
Prostatectomy, endoscopic 37203,37206
open 37200
radical 37210,37211
Prostatic abscess, endoscopic drainage of 37221
abscess, open drainage of 37212
coil, insertion of 37223
Prosthesis, breast, manipulation fibrous tissue
surrounding
breast, removal and/or replacement 45548,45551-45555
knee, removal of 49515
oesophageal, insertion of 30490
shoulder, removal of 48927
Pseudarthrosis, bone grafting of metatarsal for 46402,46405
bone grafting of phalanx for 46402,46405
Pterygium, removal of 42686
Ptosis of eyelid, correction of 45623-45625
breast, correction of (unilateral) 45556,45557
Pulmonary artery, banding of 38715,38718
artery catheterisation 13818
decortication with thoracotomy 38421
Pulp space infection of foot, incision for 47912
space infection of hand, incision for 46525
Pulse generator, subcutaneous placement 39134
Pump or resevoir, loading of 14218
implanted, associated with adjustable gastric band 31441
Punch biopsy of synovial membrane 30087
Punctum, occlusion of 42620-42622
snip operation 42617
Purse string ligation, cervix 16511
string ligature of cervix, removal 16512
Puva therapy 14050,14053
Pyelography retrograde, preparation for 36824

Pyelolithotomy 36540,36543
Pyeloplasty, by open exposure 36564,36567,36570
Pyeloscopy, retrograde 36652,36654,36656
Pyelostomy, open 36552
Pyloromyotomy for pyloric stenosis 43930
Pyloroplasty 30375
reconstruction of 30517
Pylorus, dilation of, with vagotomy 30502
Pyonephrosis, drainage of 36537

Q

Quadriceps, patella, reconstruction, congenital dislocation 50420
Quadricepsplasty, for knee mobilisation 49569
Quinsy, incision of 41807

R

Radial vessel, ligation or exploration, other 34106
Radiation dosimetry 15518,15521,15524 15527,15530,15533,15536
field setting 15500,15503,15506 15509,15512,15513,15515
oncology treatment 15211,15214,15215 15218,15221,15224,15227,15230,15233,15236,15239 15242,15245,15248,15251,15254,15257,15260,15263 15266,15269,15272
proctitis, anorectal application of formalin 32212
Radiofrequency ablation
destruction/non-resectable liver cancer 50950,50952
endometrial 35616
Radioisotope, therapeutic dose, administration of16003,16006,16009 16012
Radiosurgery, stereotactic 15600
Radiotherapy, deep or orthovoltage 15100,15103,15106 15109,15112,15115
planning 15500,15503,15506 15509,15512,15513,15515,15518,15521,15524,15527 15530,15533,15536
radioactive sources, sealed 15303,15304,15307 15308,15311,15312,15315,15316,15319,15320,15323 15324,15327,15328,15331,15332,15335,15336,15338 15339,15342,15345,15348,15351,15354,15357
radioactive sources, unsealed 16003,16006,16009 16012,16015,16018
superficial 15000,15003,15006 15009,15012
Radioulnar joint, dislocation, treatment of 47024,47027
joint, distal, reconstruction/stabilisation 46345
joint, distal, synovectomy 46342
Radius, bone graft to 48218,48221,48224 48227
fracture, treatment of 47360,47363,47366 47369,47372,47375,47378,47381,47384-47387,47390 47393,47396,47399,47402,47405,47408
fracture, treatment of paediatric 50500,50504,50508 50512,50516,50520,50524,50528,50532,50536,50540 50544,50548
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
Ranula, removal of 30282,30283
Rectal biopsy, full thickness 32096
fistula, closure of 37038,37336
polyp, removal of with sigmoidoscopy 32078,32081
prolapse, abdominal rectopexy of 32117
prolapse, Delorme procedure for 32111
prolapse, paediatric, injection under GA 44105
prolapse, perineal recto-sigmoidectomy for 32112
prolapse, perineal repair of 32120
prolapse, rubber band ligation of 32135
prolapse, sclerotherapy for 32132
stricture, dilatation of 32115
stricture, per anal release of 32114
tumour, excision of 32099,32102-32104,32106 32108
Rectocele, perineal repair of 32131
vaginal compartment repair of 35571
Rectopexy, abdominal, of rectal prolapse 32117
Rectosigmoidectomy (Hartmann's operation) 32030
perineal, for rectal prolapse 32112
Rectovaginal fistula, repair of 35596
Rectum and anus, abdomino-perineal resection of32039,32042,32045 32046
anterior resection of 32024-32026,32028
examination under GA, paediatric 44102
perineal resection of 32047
suction biopsy of 30071
Recurrent hernia, repair of 30403
Reduction mammaplasty (unilateral) 45520
with surgical repositioning of nipple 45520
without surgical repositioning of nipple 45522
Reduction ureteroplasty 36618
Reflux, gastro-oesophageal, correction 43951,43954,43957
vesico-ureteric, correction 36588
Renal artery, aberrant, operation for 36537
biopsy (closed) 36561
cyst, excision of 36558
dialysis in hospital 13100,13103
pelvis, brush biopsy of, with cystoscopy 36821
transplant 36503,36506,36509
repair of abdominal aortic aneurysm 33116,33119
Resevoir, implanted associated with gastric band 14215,31441
or pump, loading of 14218
Resuturing of wound following intraocular procedures 42857
Retina, cryotherapy of 42728,42818
detached, diathermy or cryotherapy for 42773
detached, removal of encircling silicone band 42812
detached, resection or buckling operation for 42776
detached, revision operation for 42779
light coagulation for 42782,42783
photocoagulation of 42809
pre-detachment of, cryotherapy for 42818
Retrobulbar abscess, operation for 42572
injection of alcohol 42824
Retrolabyrinthine vestibular nerve section 41596
Retroperitoneal abscess, drainage of 30402
lymph node biopsies 35723
lymph node dissection 37607,37610
neuroendocrine tumour, removal of 30321,30323
Retropharyngeal abscess, incision with drainage 30223
Retropubic prostatectomy 37200
Retroversion, operation for 35683,35684
Rhinophyma, carbon dioxide laser ablation/excision 45652
shaving of 45653
Rhinoplasty procedures 45632,45635,45638 45639,45641,45644
secondary revision of 45650
Rhinotomy, lateral, with removal of tumour 41728
Rhizolysis, spinal 40330
Rib, cervical, removal of 34139
first, resection of portion 34136
fracture, treatment of 47471
operation for acute osteomyelitis 43503
operation for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
resection, with radical operation for empyema 38415
Ring fixator, adjustment of 50309
Rod, plate or nail, removal of 47930
rods, re-exploration for adjustment /removal 48615
Rosen incision, myringoplasty 41527

Rotational atherectomy, of the coronary artery 38309,38312,38315
38318
Rotator cuff of shoulder, repair of 48906,48909
Round window repair or cochleotomy 41614
Roux-en-Y biliary bypass 30460,30466,30467
Rovsing's operation 36537
Rubin test for patency of Fallopian tubes 35706
Ruptured medial palpebral ligament, repair of 42854
membranes, threatened premature labour 16508
muscle, repair of 30232,30235
thoracic aorta, operative management of 38572
urethra, repair of 37306,37309
viscus, simple repair of 30375

S

Sacral nerve lead(s) 36663
Sacral sinus, excision of 30675,30676
colpopexy 35597
nerve stimulation for faecal incontinence 32213-32218
sympathectomy 35012
Sacro-iliac joint, arthrodesis of 49300
joint disruption, treatment of 47513
Sacrococcygeal and presacral tumour, excision of 32036
teratoma, neonatal, excision of 43876,43879
sacrospinous colpopexy 35568
Salivary gland, major, transposition of duct 41910
gland, operations on 30262,30265,30266
30269
Salpingectomy, laparoscopic 35638
with laparotomy, not with hysterectomy 35712,35713,35716
35717
with vaginal hysterectomy 35673
Salpingo-oophorectomy not with hysterectomy35712,35713,35716
35717
Salpingolysis 35694,35697
Salpingostomy 35694,35697
laparoscopic 35638
Saphenous vein anastomosis 34809
Scalene node biopsy 30096
Scalenotomy 34133
Scalp vein catheterisation in a neonate 13300
Scaphoid, bone graft to 48230,48233,48236
Scapula, fracture, treatment of 47468
(other than acromion), osteectomy/osteotomy 48406,48409
operation for chronic osteomyelitis 43512
Scar, abrasive therapy to 45021,45024
face or neck, revision of (restriction applies) 45506,45512
in oral and maxillofacial region 45801,45803,45805
45807
other than face or neck, revision of (restriction) 45515,45518
other, removal of 31200,31205,31210
31215,31220,31225,31230,31235,31240
Scars, corneal, removal of, by partial keratectomy 42647
Sclera, removal of imbedded foreign body 42644
removal of superficial foreign body 30061
transplantation of 42662,42665
Scleral blood vessels, laser coagulations of 42797
graft to lid 42860
Sclerectomy and iridectomy for glaucoma 42746
Sclerosant fluid, injection of into pilonidal sinus 30679
injection of starburst vessels, head/neck 30213,30214
injection of telangiectases, head/neck 30213,30214
Scoliosis, treatment of 48606,48612,48613
48615,48618,48621,48624,48627,48630,48632
anterior correction of (Dwyer procedure) 48621,48624
application of halo 47714
bone graft to 50644
congenital, vertebral resection and fusion for 48632,50640
re-exploration for 48615,50616
requiring anterior decompression of spinal cord 48630,50636
revision of failed surgery 48618,50620
spinal fusion for 48606,48612,48613
spinal fusion for, with segmental instrumentation48612,48613,48627
spinal fusion with use of Harrington rod 48681
treatment of including paediatric 50600,50604,50608
50612,50616,50620,50624,50628,50632,50636,50640
50644
Screw, pin or wire, buried, removal of 47924,47927
Scrotal contents, exploration of 37604
Scrotum, excision of abscess of 30223
partial excision of 37438
Second trimester labour, management of 16525
Secondary, repair of extensor tendon of hand or wrist 46423
repair of flexor tendon of hand or wrist 46429
Segmentectomy 38438
Selective coronary angiography 38215,38218,38220
38222,38225,38228,38231,38234,38237,38240,38241
38243,38246
internal radiation therapy 35404,35406,35408
Semen, collection of 13290,13292
Semimembranosus bursa, excision of 30114
Seminal vesicle/ampulla of vas, total excision of 37209
Sengstaken-Blakemore tube, insertion of 13506
Sentinel lymph node biopsy for breast cancer 30299,30300,30302
30303
Septal defect, atrial, closure of 38742
defect, ventricular, closure of 38751
perforation, closure of 41671
Septectomy, cardiac 38739,38748
Septoplasty of nasal septum 41671
Septostomy, or balloon valvuloplasty 38270
Septum button, nasal, insertion of 41907
nasal, cauterisation/diathermy 41674
nasal, reconstruction of 41672
nasal, septoplasty or submucous resection 41671
vaginal, excision of, for correction of double vagina 35566
Sequestrectomy 43512,43515,43518
43521,43524
Seroma, breast, exploration, drainage, operating
theatre 31551
Sesamoid bone, osteotomy or osteectomy of 48400
Seton, readjustment of, in anal fistula 32166
Shirodkar suture 16511
Shoulder, amputation or disarticulation at 44331
arthrectomy or arthrodesis 48939,48942
arthroscopic surgery 48948,48951,48954
48957,48960
arthroscopy 48945
arthrotomy 48912
dislocation, treatment of 47009,47012,47015
hemi-arthroplasty of 48915
open reduction for congenital dislocation 50408
orthopaedic treatment of 48900,48903
prosthesis, removal of 48927
removal of calcium deposit from cuff 48900
rotator cuff, repair of 48906,48909
spica, application of 47540
Stabilisation procedure for recurrent anterior or
posterior dislocation 48930
stabilisation, for multidirection instability 48933
synovectomy of 48936
total replacement of 48918,48921,48924
Shunt, aorto-pulmonary or cavo-pulmonary 38733,38736
arteriovenous, external, insertion/removal 34500,34506
cranial or cisternal, insertion of 40003
cranial or cisternal, revision or removal of 40009
lumbar, insertion of 40006
lumbar, revision or removal of 40009
Sigmoidoscopic examination 32072,32075
- with diathermy or resection of polyp/s 32078,32081
Sigmoidoscopy, fibreoptic, flexible 32084,32087

Silicone band, encircling, removal from detached retina 42812
breast prosthesis, removal of 45555
Sinoscopy 41764
Sinus, diathermy of
ethmoidal, external operation on 41749
excision of 30099,30102,30103
frontal, catheterisation of 41740
frontal, radical obliteration of 41746
frontal, trephine of 41743
injection of sclerosant fluid under anaesthesia 30679
intranasal operation on 41737
maxillary, drainage of, through tooth socket 41719
pilonidal, excision of 30675,30676
pre-auricular, excision of 30104
sphenoidal, intranasal operation on 41752
urogenital, vaginal reconstruction for 35565
SIR-Spheres administration 35404,35406,35408
Skin, biopsy of 30071
cancer, treatment of 30196,30197,30202
30203,30205
full face chemical peel 45019,45020
graft to orbit 42524
lesions, multiple injections for 30207
lesions, treatment of 30192,30195
malignant lesion, removal of 31300,31305,31310
31315,31320,31325,31330,31335
repair of recent wound of 30026,30029,30032
30035,30038,30041,30042,30045,30048,30049
subcutaneous tissue, extensive excision 31245
tags, anal, excision of 32142,32145
Skull base surgery for tumour removal 39640,39642,39646
39650,39653,39654,39656,39658,39660,39662
base tumour, removal, infra-temporal 41581
calipers, insertion of 47705
fracture, attendance for treatment of 47703
fractured, operations for 39606,39609,39612
39615
osteomyelitis, acute, operation for 43503
osteomyelitis, chronic, operation for 43521
osteomyelitis, craniectomy for 39906
treatment of fracture, not requiring operation 47703
tumour, excision of 39700
Sling operation for stress incontinence 35599
procedure, intestinal, prior to radiotherapy 32183
Slough, debridement of 35100,35103
Small bone, exostosis, excision of 47933
bowel intubation 30487,30488
bowel strictureplasty 30564
bowel, endoscopic examination of 32095
intestine, resection of 30565,30566
Smith's fracture of radius, treatment of 47369,47372,47375
Smith-Petersen nail, removal of 47924,47927
Socket, eye, contracted, reconstruction of 42527
Spasticity management
implanted drug delivery system 14227,14230,14233
14236,14239,14242
Spermatic cord, exploration of, inguinal approach 30644
Spermatocele, excision of 37601
Sphenoidal sinus, intranasal operation on 41752
Sphincter, anal, direct repair of 32129
anal, stretching of 32153
bladder, endoscopic incision/resection 36854
of Oddi, transduodenal operation on 30458
urethral, reconstruction 37375
urinary, artificial, insertion 37381,37384,37387
urinary, artificial, revision or removal 37390
Sphincterotomy, anal, independent procedure 43999
endoscopic 30485,36854
Spinal and pudendal nerve motor latency, measurement
catheter, insertion of for infusion device 39125,39128
cord, cervical decompression 40331-40335
fusion to cervical, thoracic or lumbar regions48660,48663,48666
48669,48672,48675
fusion, application of halo for scoliosis 47714
fusion, posterior 40321,40324,40327
fusion, posterior interbody, with laminectomy 48654,48657
nerves, injection into 39013
nerves, percutaneous neurotomy 39115
neurostimulator receiver, subcutaneous placement 39134
rhizolysis 40330
shunt for hydrocephalus 40006
spinal stimulation, for pain 39131,39133-39139
stenosis, laminectomy for 40303,40306
thoracic decompression 40345,40348
thoraco-lumbar/high lumbar decompression 40351
using segmental instrumentation 48613
Spine, application of plaster jacket to 47708
application of a localiser cast to 50600
bone graft to 48642,48645,48648
48651
fracture, treatment of 47681,47684,47687
47690,47693,47696,47699,47702
internal fixation of 48678,48681,48684
48687,48690
manipulation of 48600,48603
operation on, for acute osteomyelitis 43509
operation on, for chronic osteomyelitis 43518
Spleen, ruptured, repair of 30375
Splenectomy 30597,30599
laparoscopic 31470
Spleno renal shunt, selective, for portal hypertension 30605
Splenorrhaphy 30596
Split skin free grafts, granulating areas 45400,45403
skin free grafts to one defect 45439,45442,45445
45448
Squamous cell carcinoma, removal of31255-31258,31260-31263,31265-3126
31270-31273,31275-31278,31280-31283,31285-31288
31290-31293,31295
Squint, muscle transplant (Hummelsheim type) 42848
operation for 42833,42836,42839
42842
readjustment of adjustable sutures 42845
recurrent, operation for 42851
Staging laparotomy for gynaecological malignancy 35726
Stapedectomy 41608
Stapes mobilisation 41611
Staple arrest of hemi-epiphysis 48509
Starburst vessels, head/neck, diathermy or injection 30213,30214
Stenosing tendovaginitis, hand/wrist, open operation 46363
Stenosis, arteriovenous fistula/access device,
correction of 34518
auditory canal, correction of 41521
spinal, laminectomy for 40303,40306
tracheal, dilatation of, with bronchoscopy 41904
venous, operations for 34812,34815
Stent, external, application restore valve competency34824,34827,34830
34833
insertion, transluminal 35306,35307,35309
insertion, transluminal, rotational atherectomy 38312,38318
ureteric, passage through nephrostomy tube 36604
Stereotactic procedures 40800,40801,40803
Sterilisation (female) 35687,35688
in conjunction with Caesarean section 35691
Sternal wire/s, removal of 38460
Sternocleidomastoid muscle, bipolar release,
torticollis 50402
Sternotomy for removal of thymus or mediastinal tumour 38446
involving division of adhesions 38643,38647
median, for post-operative bleeding 38656
wound, debridement of 38462,38464
Sternum and mediastinum, reoperation for infection 38468,38469
biopsy of 30081,30084,30087

fracture, treatment of 47466,47467
operation for acute osteomyelitis 43503
operation for chronic osteomyelitis 43512
reoperation for dehiscence or infection 38466
Stomach lavage
lavage in the treatment of ingested poison 14200
Stone/s, biliary/renal tract, extraction of
removal of, by urethroscopy 36540,36543
Strabismus, operation for 42833,42836,42839
Stress incontinence, abdomino-vaginal operation 35602,35605
Marshall-Marchetti, urethropexy 35599,37044
sling operation 35599,37042
Stamey or similar type needle colposuspension 37043
suprapubic procedure for 37044
Stricture, anal, anoplasty for 32123
oesophagus, dilatation of 41819
rectal, dilatation of 32115
rectum, plastic operation to 30387
tracheal, dilatation of, with bronchoscopy 41904
urethral, dilatation of 37303
Strictureplasty, small bowel 30564
Strontium 89, administration of 16015
Stump, amputation, reamputation of 44376
cervix-residual, removal of, abdominal approach 35612
cervix-residual, removal of, vaginal approach 35613
Styloid process of temporal bone, removal of 30244
Sub-valvular structures, heart, reconstruction, re-
implant 38490
Subclavian artery, endarterectomy 33506
to femoral bypass grafting 32715
vessel, ligation/exploration, other 34103
Subcutaneous fasciotomy, Dupuytren's contracture 46366
fistula in ano, excision of 32156
foreign body, removal not otherwise covered 30064
tenotomy 47960
tissue, repair of recent wound of 30026,30029,30032
30035,30038,30041,30042,30045,30048,30049
Subdural haemorrhage, tap for 39009
Sublingual gland, duct, removal of calculus 30265,30266
gland, extirpation of 30259
gland, meatotomy or marsupialisation 30265,30266
Submandibular abscess, incision of 30223
ducts, relocation of 30255
gland, extirpation of 30256
Submaxillary gland, repair of cutaneous fistula 30269
Submucous resection of nasal septum 41671
resection of turbinates 41692
Subperiosteal abscess 43500,43503,43506
43509,43512,43515,43518,43521,43524
Subphrenic abscess, laparotomy for drainage of 30394
Subtalar arthrodesis 50118
Subtemporal decompression 40015
Subungual haematoma, incision of 30219
Suction biopsy of rectum 30071
curettage of uterus 35639,35640,35643
Supraglottic laryngectomy with tracheostomy 41840
Suprapubic cystostomy or cystotomy 37008
prostatectomy 37200
stab cystotomy 37011
Surgical reduction of enlarged elements, macrodactyly 46510
Suspension of uterus 35683,35684
Suture, laser division of, eye, following
trabeculoplasty 42794
shirodkar 16511
traumatic wounds 30026,30029,30032
30035,30038,30041,30042,30045,30048,30049
Sutures, adjustable, readjustment of, for squint 42845
dressing and removal of, requiring GA 30055
Swann-Ganz catheterisation 13818
Sweat, collection of specimen of, by iontophoresis
gland bearing area, excision of 30180,30183
Sycosis barbae/nuchae, excision of 31245
Symblepharon, grafting for 45629
Syme's amputation of foot 44361
Sympathectomy, chemical
surgical 35000,35003,35006
35009,35012
Symphysis pubis, fracture, treatment of 47474,47477,47480
47483,47486,47489
Synacthen stimulation testing 30097
Synechiae, division of 42761
Synovectomy, of ankle 50312
of elbow 49109
of finger joints 46336
of hand tendons 46336,46342
of joint, not otherwise covered 50104
of metatarso-phalangeal joint 49860,49863
of shoulder 48936
of tendons of digit 46348,46351,46354
46357,46360
total, of knee 49509
total, of wrist 49224
Synovial cavity, aspiration of
membrane, punch biopsy of 30087

T

Talipes equinovarus, cast/manipulation/splint 49878
equinovarus, procedures for 50315,50318,50321
50324,50327,50330
Talus fracture, treatment of 47606,47609,47612
47615,47618
vertical, congenital, reconstruction 50336
Tantalum markers, surgical insertion of 42805
Tarsometatarsal joint, fracture, treatment of 47621,47624
joint, Lisfranc's amputation of 44364
Tarsorrhaphy 42584
Tarsus, dislocation, treatment of 47063,47066
fracture, treatment of 47627,47630
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
Tear duct, probing of 42610,42611,42614
42615
third degree, repair of 16573
Teflon injection, into vocal cord 41870
injection, peri-urethral 37339
Telangiectases, head/neck, diathermy or injection of 30213,30214
Temporal artery, biopsy of 34109
bone, reconstruction of 45788
bone, removal of styloid process of 30244
bone, resection for removal of tumour 41584,41587
Temporomandibular joint, arthroplasty 45758
arthrodesis 45877
arthroscopy of 45855,45857
arthrotomy 45859
joint, external fixation, application of 45879
joint, irrigation of 45865
joint, manipulation of 45851
joint, open surgical exploration of 45861,45863,45865
45867,45869,45871,45873
meniscectomy 45755
stabilisation of 45875
synovectomy of 45867
Tendon 49718,49721,49724
49727
- Achilles, repair of 49718,49721,49724
49727
- artificial prosthesis, insertion of for grafting 46414
- foot, adductor hallucis, transfer of 49827,49830
- foot, repair of 49800,49803,49806
49809,49812

- foreign body in, removal 30067,30068
- hand/digit, synovectomy of 46336,46339,46342 46345,46348,46351,46354,46357,46360
- hand/wrist, repair of 46420,46423,46426 46429,46432,46435
- lengthening of 47957,47960,47963
- major, of ankle, repair of 49718,49721,49724 49727
- or ligament transfer 47966
- prosthesis, artificial, insertion for grafting 46414
- reconstruction of, by tendon graft 46408
- repair of 47954,49718
- sheath, open operation for tenovaginitis 46363,47972
- tenotomy 47960,47963
- transfer of, to restore elbow function 50405
- transfer of, to restore hand function 46417
- transplantation of 47966

Tenolysis, hand 46450,46453
Tenoplasty 47963
Tenosynovectomy 47969
Tenosynovitis, open operation, tendon sheath hand/wrist 46363
Tenotomy 47960,47963,49806 49809
percutaneous, of finger 46456
Tenovaginitis, open operation for 46363,47972
Teratoma, mediastinal, thoracotomy and excision 43912
sacrococcygeal, neonatal, excision of 43876,43879
Testicular implant 45051
Testis, exploration of 37604
impalpable, exploration of groin 37812
undescended, orchidopexy for 37803,37806,37809
Testopexy 37803
Tethered cord, release of 40112
Thenar spaces of hand, drainage of 46519
Therapeutic haemapheresis 13750
Therapeutic venesection 13757
Thigh, amputation through 44367
hamstring tendon transfer 50357,50360
rectus femoris tendon transfer 50357
Third degree tear, repair of 16573
ventriculostomy 40012
Thompson arthroplasty of hip 49315
Thoracic aneurysm, replacement by graft 33103
aorta, operative management of rupture/dissection 38572
aorta, repair or replacement procedures 38550,38553,38556 38559,38562,38565,38568,38571
cavity, aspiration of 38800,38803
decompression of spinal cord 40345,40348
outlet compression, removal operation 34139
sympathectomy 35003,35006
Thoraco-lumbar decompression of spinal cord 40351
Thoracoplasty 38427,38430
Thoracoscopy 38436
Thoracotomy 38418,38421,38424
and excision of cyst/teratoma 43912
for congenital cystadenomatoid malformation 43861
for congenital lobar emphysema 43861
for oesophageal atresia, neonatal 43852
for removal of thymus or mediastinal tumour 38446
involving division of adhesions 38643,38647
or median sternotomy for post-operative bleeding 38656
Threatened abortion, treatment of 16505
miscarriage, purse string ligation of cervix 16511
miscarriage, treatment of 16505
premature labour, treatment of 16502,16508
Three snip operation 42617
Thrombectomy of arteriovenous access device 34515
of artery or vein 33803,33806,33812
Thrombosis, peri-anal, incision of 32147
reoperation on extremity for 33848
Thrombus, removal of 33803,33806,33812
Thumb, digital nail, removal of 46513,46516
flexor tendon sheath, open operation 46522
fractures, treatment of 47300,47303,47306 47309,47312,47315,47318,47321,47324,47327,47330 47333
ingrowing nail, resection 46528,46531
Thymectomy 38456
Thymoma, malignant, removal from mediastinum 38456
Thymus, removal of by thoracotomy or sternotomy 38446
Thyroglossal cyst and/or fistula, removal of 30313,30314
Thyroidectomy 30296,30297,30299 30300,30302,30303,30306,30308-30310
Tibia, bone graft to 48206,48209
congenital deficiency, treatment of 50417,50423
congenital pseudarthritis, resection, fixation 50354
epiphyseodesis 48503,48506
fracture, treatment of 47543,47546,47549 47552,47555,47558,47561,47564-47567,47570,47573
fracture, treatment of paediatric 50580,50584,50588
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48418,48421
Tibial vessel, ligation/exploration not otherwise covered 34106
Tic douloureux, injection for 39100
Tissue, expansion for breast reconstruction 45539,45542
expander, insertion of 45566
expander, removal of 45568
expansion, intra-operative 45572
free transfer of 45563-45565
living, implantation of 14203,14206
subcutaneous, repair of recent wound of 30026,30029,30032 30035,30038,30041,30042,30045,30048,30049
Toe, amputation or disarticulation of 44338,44342,44346 44350,44354,44358
dislocation, treatment of 47069,47072
fractures, treatment by reduction 47663,47666,47672 47678
hammer or claw, correction of 49848,49851
hyperextension deformity, release, lengthening 50345
phalanx of, operation for acute osteomyelitis 43500
Toenail, ingrowing, excision or resection for 47915,47916,47918
ingrown, operation with GA, paediatric 44136
removal of 47904,47906
Tongue, partial or complete excision of 30272,41779,41782 41785
tie, repair of 30278,30281
Tonsils, lingual, removal of 41804
or tonsils and adenoids 41796,41797
- removal of, twelve years or over 41792,41793
- removal of, under twelve years 41788,41789

Topectomy, for epilepsy 40703
Torkildsen's operation 40000
Torticollis, bipolar release sternocleidomastoid muscle 50402
operation for 44133
Trabeculectomy for glaucoma 42746,42783
Trabeculoplasty, laser, of eye 42782
Trachea, dilatation of stricture and stent insertion 41905
removal of foreign body from 41886
Tracheal excision, repair, with cardiopulmonary bypass 38455
excision, repair, without cardiopulmonary bypass 38453
stricture, dilatation of with bronchoscopy 41904
Trachelorrhaphy 35617,35618
Tracheo-oesophageal fistula, division and repair 43900
formation of, including enoscopic procedures 41885
Tracheomalacia, aortopexy for 43909
Tracheoplasty or laryngoplasty with tracheostomy 41879
Tracheostomy
by open exposure of the trachea 41881
closure of 30102,30103
percutaneous technique, sequential dilation, partial

splitting method 41880
using Minitrach or similar device 41884
with laryngoplasty or tracheoplasty 41879
with supraglottic laryngectomy 41840
with vertical hemi-laryngectomy 41837
Transanal
transanal endoscopic microsurgery 32103,32104,32106
Transantral ethmoidectomy with radical antrostomy 41713
ligation of maxillary artery 41707
vidian neurectomy 41713
Transfusion 13703,13706
collection of blood for 13709
paediatric/neonatal 13306,13309
Transillumination, ocular 42821
Translabyrinthine vestibular nerve section 41593
Transluminal balloon angioplasty 35300,35303
rotational atherectomy with stent insertion 38312,38318
rotational atherectomy without stent insertion 38309,38315
stent insertion 35306,35309
Transmastoid decompression of endolymphatic sac 41590
removal of glomus tumour 41623
Transmetacarpal amputation of hand 44325
Transmetatarsal amputation of foot 44364
Transorbital ligation of ethmoidal arteries 41725
Transplantation, cornea 42653,42656,42659
ureter 36585,36588,36591
36594,36597,36600,36603
Transposition of digit 46507
of nerve 39321
Transpupilliary thermotherapy 42811
Transthoracic drainage of pericardium 38450
Transtympanic removal of glomus tumour 41620
Transurethral injection for urinary incontinence 37339
Transvenous electrode/s, permanent, insertion of 38350,38356
pacemaking electrode, temporary, insertion of 38256
Treacher Collins Syndrome, peri-orbital correction of 45773
Trephine of frontal sinus 41743
Trichiasis, treatment of 42587
Trichoepitheliomas, face/neck, removal by laser
excision 30190
Trigeminal gangliotomy, radiofrequency/balloon/glycerol 39109
nerve, injection with alcohol, cortisone etc 39100
neuralgia, intracranial neurectomy 39106
Trigger finger, correction of 46363
Tubed pedicle or indirect flap 45230
- formation of 45227
- preparation of site and attachment to site 45233
- spreading of pedicle 45236
Tuboplasty 35694,35697
tubuerous, tubular or constricted breast, treatment by 45559
Tumour, adrenal gland, excision of 30324
benign, of soft tissue, removal 31350
bladder, diathermy/resection with cystoscopy 36840,36845
bladder, laser destruction with cystoscopy 36840
bone, benign, requiring allograft, resection of 50230
bone, innocent, excision of 30241
bone, malignant, operations for 50200,50201,50203
50206,50209,50212,50215,50218,50221,50224,50227
50230,50233,50236,50239
broad ligament, removal of 35712,35713,35716
35717
cardiac, excision of 38670,38673,38677
38680
carotid body, resection of 34148,34151,34154
cerebello-pontine angle, removal of 41575,41576,41578
41579
deep, peripheral nerve, removal of 39327
endocrine, exploration of 30578,30580,30581
extradural, laminectomy for 40309
face/neck, laser excision 30190
gastric, removal of 30520
glomus, removal of 41620,41623
gynaecological, radical or debulking operation 35720
intra-oral, radical excision of 30275
intra-temporal fossa, removal of 41578
intracerebral, craniotomy and removal of 39709
intracranial, biopsy/decompression, osteoplastic flap 39706
intracranial, burr-hole biopsy or drainage 39703
intracranial, craniotomy and removal of 39709,39712
intramedullary, laminectomy for 40318
involving ciliary body an/or iris, excision of 42767
iris, excision of 42764
larynx, removal of 41852
limbic, removal of 42692
lipoma, liposuction or surgical removal of 31345
malignant of soft tissue, removal of 31355
malignant upper aerodigestive tract 31400,31403,31406
malignant, bone, operations for 50200,50201,50203
50206,50209,50212,50215,50218,50221,50224,50227
50230,50233,50236,50239
malignant, skin, removal of 31300,31305,31310
31315,31320,31325,31330,31335
mandible, segmental resection for 45605
mediastinal, removal by thoracotomy or sternotomy 38446
microlaryngoscopy with removal of 41864
neuroendocrine, removal of 30321,30323
other, removal of (restriction applies) 31200,31205,31210
31215,31220,31225,31230,31235,31240
ovarian, radical or debulking operation for 35720
parapharyngeal, excision of, cervical approach 31409,31412
parathyroid, removal of 30306
parotid gland, removal of 30253
parotid, excision of 30251
peripheral nerve, removal from 39324,39327
pituitary, hypophysectomy or removal of 39715
rectal, excision of 32099,32102,32108
removal of, by laminectomy 40309,40318
removal of, by lateral rhinotomy 41728
removal of, by neurectomy, neurotomy 39327
removal of, by temporal bone resection 41584,41587
removal of, by urethrectomy 37330
removal of, in oral and maxillofacial region 45801,45803,45805
45807,45809,45811,45813
sacrococcygeal and presacral, excision of 32036
skin, malignant, removal of 31300,31305,31310
31315,31320,31325,31330,31335
skin, micrographic serial excision 31000-31002
skull base, removal of 39640,39642,39646
39650,39653,39654,39656,39658,39660,39662
skull, excision of 39700
spinal, laminectomy for 40318
thyroid, removal of 30310
vagina, simple, removal of 35557
vocal cord, removal from 41852
Tunnelled cuffed catheter
central vein, for haemodialysis or parenteral nutrition 34538
removal 34539
Turbinates, cauterisation or diathermy of 41674
dislocation, treatment of 41686
submucous resection of 41692
Turbinectomy 41689
Turricephaly, cranial vault reconstruction for 45785
Tympani, paracentesis of 41626
Tympanic membrane, micro-inspection of 41650
membrane, micro-inspection with ear toilet 41647
Tympanum, perforation, cauterisation or diathermy 41641

U

Ulcer, corneal, epithelial debridement for 42650
duodenal, perforated, suture of 30375
gastric, perforated, suture of 30375

other, removal of 31200,31205,31210 31215,31220,31225,31230,31235,31240
peptic, bleeding, control of 30505,30506,30508 30509
peptic, perforated, suture of 30375
Ulna, bone graft to 48218,48221,48224 48227
fracture, treatment of 47360,47363,47366 47369,47372,47375,47378,47381,47384-47387,47390 47393,47396,47399,47402,47405,47408
fracture, treatment of paediatric 50500,50504,50508 50512,50516,50520,50524,50528,50532,50536,50540
operation on, for acute osteomyelitis 43503
operation on, for chronic osteomyelitis 43512
osteectomy or osteotomy of 48406,48409
Ulnar vessel, ligation/exploration not otherwise covered 34106
Ultrasound, intraoperative, biliary tract 30439
staging of intra-abdominal tumours 30441
Umbilical artery catheterisation 13303
granuloma, excision under GA 43948
hernia, repair of 30616,30617,30620 30621
vein catheterisation in a neonate 13300
Undescended testis, orchidopexy for 37803,37806,37809
Unstable lie, attendances other than routine antenatal 16502
Urachus, patent, excision of 37800
Ureter, brush biopsy of, with cystoscopy 36821
divided, repair of 36573
exploration of 36612
retrocaval, correction of, by open exposure 36564,36567
transplantation of 36597
- into bladder 36588,36591
- into intestine 36594
- into isolated intestinal segment 36600,36603
- into skin 36585
Ureterectomy 36579
Ureteric calculus, endoscopic extraction/manipulation 36857
catheterisation with cystoscopy 36818,36824
dilatation 36821
meatotomy 36830
reflux, correction of 36588
stent, insertion of 36605,36607,36821
stent, removal/replacement of 36825
stent, through nephrostomy tube 36604
Ureterolithotomy 36549
complicated by previous surgery 37444
Ureterolysis 36615
Ureteroplasty 36618
Ureteroscopy 36803,36806,36809
Ureterostomy, cutaneous, closure of 36621
revision of 36609
Urethra, cauterisation of 35523
diathermy of 37318
diverticulum, excision of 37372
endoscopic examination with cystoscopy 36812
laser therapy, intraepithelial neoplasia 35539,35542,35545
prolapsed, excision of 37369
ruptured, repair of 37306,37309
Urethral abscess, drainage of 30223
caruncle, cauterisation of 35523
caruncle, excision of 35526,35527
dilatation with cystoscopy 36812
diverticulum, excision of 37372
fistula, closure of 37333,37336,37833
prosthesis, with cystoscopy 36811
reconstruction, hypospadias/epispadias 37815,37827,37830
sounds, passage of, as an independent procedure 37300
sphincter, reconstruction of 37375
stricture, dilatation of 37303
stricture, optical urethrotomy for 37327
stricture, plastic repair of 37342,37343,37345 37348,37351
tumour, removal of by urethrectomy 37330
valves, destruction of 37854
warts, cystoscopy for the treatment of 36815
Urethral sling, division or removal of 37340,37341
Urethrectomy 37330
Urethrocoele, repair of 35570
repair of 35570,35573
Urethropexy (Marshall-Marchetti operation) 35599,37044
Urethroplasty 37342,37343,37345 37348,37351
Urethroscopy, as an independent procedure 37315
with biopsy/diathermy/foreign body/stone 37318
with cystoscopy 36812
with cystoscopy and injection for incontinence 37339
with laser destruction of stone 37318
Urethrostomy 37324
Urethrotomy, external or internal 37324
optical, for urethral stricture 37327
Urinary conduit or reservoir, endoscopic examination 36860
conduit, revision of 36609
reservoir, formation of 36606
sphincter, artificial 37381,37384
- insertion of pressure regulating balloon, pump 37387
- revision or removal of 37390
Urogenital sinus, vaginal reconstruction for 35565
Uterine adenomyoma, excision of 35649
adhesiolysis, with hysteroscopy 35633
adhesions, laparoscopic division 35638
adnexae, removal, with abdominal hysterectomy 35653
artery embolisation 35410
myomectomy 35649
septum, hysteroscopic resection 35623
tubes, insufflation of, for patency (Rubin test) 35706
Utero-sacral ligaments, laparoscopic division 35638
Uterus, acute inversion, vaginal correction 16570
bicornuate, plastic reconstruction for 35680
curettage of 35639,35640
debulking prior to vaginal hysterectomy 35658
gravid, evacuation of contents 35643
implantation of Fallopian tubes into 35694,35697
suspension or fixation of 35683,35684
UVB therapy 14050,14053
Uvula, excision of 41810
Uvulectomy and partial palatectomy 41787
Uvulopalatopharyngoplasty 41786
Uvulotomy 41810

V

Vagina, artificial formation of 35565
dilatation of, as an independent procedure 35554
laser therapy, intraepithelial neoplasia 35539,35542,35545
partial or complete removal of 35560
removal of simple tumour of 35557
Vaginal correction of acute inversion of uterus 16570
compartment repair, anterior 35570
compartment repair, anterior/posterior 35573
compartment repair, posterior 35571
fistula, repair or closure of 35596,37029,37333
hysterectomy 35657,35673
orifice, plastic repair to enlarge 35569
reconstruction, congenital absence/gynatresia 35565
septum, excision for correction of double vagina 35566
upper prolapse, sacrospinous colpopexy for 35568
upper vault prolapse, pelvic floor repair 35595
upper vault prolapse, sacral colpopexy 35597
warts, removal under GA or nerve block 35507,35508
Vaginectomy, radical, for malignancy 35561,35562,35564
Vaginoplasty for congenital adrenal hyperplasia 37851

Vagotomy 30496,30497,30499
30500,30502,30503
Vallecular cysts, removal of 41813
Valve annuloplasty, heart 38475,38477,38478
leaflet/s, aortic, decalcification of 38483
mitral, open valvotomy of 38487
repair, heart 38480,38481
replacement, heart 38488,38489
Valvotomy for pulmonary stenosis 38456
open, of mitral valve 38487
Valvuloplasty, balloon or septostomy 38270
Varicocele, surgical correction of 30634,30635
Varicose veins, injection of sclerosing fluid
veins, multiple injections 32500,32501
veins, operations for 32500,32501,32504
32507,32508,32511,32514,32517
Vas deferens, operations on 37616,37619,37622
37623
Vasectomy 37622,37623
Vasoepididymostomy (unilateral) 37616,37619
Vasotomy 37622,37623
Vasovasotomy 37616,37619
Vein, anastomosis, microsurgical 45502
bypass for venous stenosis or occlusion 34812
cannulation of, in a neonate 13300
central, catheterisation 13318,13319,13815
central, catheterisation, subcutaneous tunnel 34527,34528
femoral bypass, saphenous vein anastomosis 34809
graft for priapism 37396
great, ligation or exploration not otherwise covered 34103
harvesting, leg/arm, for bypass, not same limb 32760
harvesting, leg/arm, for patch graft, not same incision 33551
intra-abdominal, cannulation, infusion chemotherapy 34521
ligation or exploration not otherwise covered 34106
major, repair of wound of 33815,33818,33821
33824,33827,33830,33833,33836,33839
patch grafting to 33545,33548
saphenous, cross leg by-pass graft 34806
scalp, catheterisation of 13300
stenosis, patch angioplasty for 34815
thrombectomy of 33810-33812
transplant to restore valvular function 34821
umbilical, catheterisation of 13300
varicose, multiple injections 32500,32501
varicose, operations for 32500
Veins, major, access as part of re-operation 35202
Velopharyngeal incompetence, flap or pharyngoplasty 45716
Vena cava, inferior, operations on 34800,34803
caval filter, insertion of 35330
Venesection
therapeutic 13757
Venography, operative 35200
Venous anastomosis, not otherwise covered 32766,32769
catheterisation, peripheral 35317,35319,35320
stenosis or occlusion, vein bypass for 34812
valve, plication or repair to restore competency 34818
Ventilation, mechanical, intensive care 13857,13881,13882
Ventral hernia following closure exomphalos, repair of 43939
hernia, repair of 30403
Ventricular aneurysm, plication of 38506
aneurysm, resection 38507,38508
assist device, insertion of 38615,38618
assist device, removal of, independent 38621,38624
augmentation 38766
chamber, operation for arrhythmia 38518
myomectomy 38763
puncture 39006
reservoir or external drain, insertion of 39015
septal defect, closure of 38751
septal rupture, ischaemic, repair of 38509
septectomy 38748
Ventriculo-cisternostomy 40000
Ventriculostomy, third 40012
Vermilionectomy 45668,45669
Version, external cephalic 16501
Vertebra, needle biopsy of 30093
Vertebral bodies, fracture, treatment of 47681,47684,47687
47690,47693,47696,47699,47702
bodies, total or sub-total, excision of 48639
diseases of, excision & spinal fusion for 48640
resection and fusion for congenital scoliosis 48632
Vesical fistula, cutaneous, operation for 37023
Vesico-intestinal fistula, closure of 37038
Vesicostomy, cutaneous, establishment of 37026
Vesicovaginal fistula, closure of 37029
Vestibular nerve section, retrolabyrinthine 41596
nerve section, translabyrinthine 41593
nerve section, via posterior fossa 39500
Vestibuloplasty, unilaterla or bilateral 45837
Vidian neurectomy, transantral, with antrostomy 41713
Villus, chorionic, sampling 16603
Viscera, abdominal, operation involving laparotomy 30387
pelvic, operation involving laparotomy 30387
Viscus, ruptured, simple repair of 30375
Vitello intestinal duct, patent, excision of 43945
intestinal remnant, abdominal wall, excision of 43942
Vitrectomy 42719,42722,42725
Vitreolysis of lens material 42791,42792
Vocal cord, biopsy of 41849
cord, removal of nodule or tumour 41852
cord, teflon injection into 41870
Volvulus, reduction of 30375
Vulva, biopsy of, with colposcopy 35615
laser therapy for intraepithelial neoplasia 35539,35542,35545
wide local excision of suspected malignancy 35536
Vulval warts, removal under GA or nerve block 35507,35508
Vulvectomy, hemi 35536
radical for malignancy 35548
Vulvoplasty, where medically indicated 35533

W

Warts, anal, removal under GA or nerve block 32177,32180
palmar or plantar, removal of 30186,30187
penile or urethral, cystoscopy for treatment of 36815
removal in operating theatre 30189
vulval/vaginal, removal, GA or nerve block 35507,35508
Wedge excision for axillary hyperhidrosis 30180
excision of lip, eyelid or ear, full thickness 45665
Wertheim's operation 35664
Whipple's operation (pancreatico-duodenectomy) 30584
Wire, orthopaedic, insertion of 47921
pin or screw, buried, removal of 47924,47927
Wolfe graft 45451
Wound, debridement under GA or major block 30023
dressing of, requiring GA 30055
resuturing following intraocular procedures 42857
traumatic, suture of 30026,30029,30032
30035,30038,30041,30042,30045,30048,30049
Wrist, arthrodesis of 49200,49203
arthroplasty of 49209
arthroscopic surgery 49221,49224,49227
arthroscopy of 49218
arthrotomy of 49212
fracture, treatment of 47369,47372,47375
osteoplasty 49224
proximal carpectomy 49206
reconstruction of 49215
revision arthroplasty 49210,49211
tendon sheath, open operation 46363
tendon, repair of 46420,46423,46426
46429,46432,46435

Wry neck, operation for 44133

X

Xenon arc photo-coagulation 42782,42783

Z

Z-plasty, in association with Dupuytren's Contracture 46384
Zygo-apophyseal joint, injection into 39013
Zygoma, osteotomy or osteectomy of 45720,45723,45726
45729,45731,45732,45735,45738,45741,45744,45747
45752
Zygomatic arch, reconstruction of 45788
bone, fracture, treatment of 45981,47762,47765
47768,47771