# **Australian Government Department of Health**

## Medicare Benefits Schedule Book Category 3

**Operating from 1 January 2020** 

Title: 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

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## **GENERAL EXPLANATORY NOTES**

#### **GENERAL EXPLANATORY NOTES**

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

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

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

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

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

#### **Explanatory Notes**

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

#### GN.1.2 Medicare - an outline

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

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

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

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

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

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

#### **GN.1.3 Medicare benefits and billing practices**

#### Key information on Medicare benefits and billing practices

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

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

#### **Billing practices contrary to the Act**

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

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

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

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

#### Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

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

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

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

#### **GN.2.4 Provider eligibility for Medicare**

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

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

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

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

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

#### Non-medical practitioners

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

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

#### **GN.2.5 Provider Numbers**

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

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

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

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

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

#### **GN.2.6 Locum tenens**

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

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

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

#### **GN.2.7 Overseas trained doctor**

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

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

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

Medicare

**GPO Box 9822** 

in your capital city

or

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

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

#### **MBS Interpretations**

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

or by phone on 132 150

#### **GN.3.9 Patient eligibility for Medicare**

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

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

#### **GN.3.10 Medicare cards**

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

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

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

#### **GN.3.11 Visitors to Australia and temporary residents**

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

#### **GN.3.12 Reciprocal Health Care Agreements**

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

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

#### **Exceptions:**

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

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

#### **GN.4.13 General Practice**

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

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

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

#### Vocational recognition of general practitioners

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

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

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

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

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

Tel: 1800 472 247 Email at: <a href="mailto:qicpd@racgp.org.au">qicpd@racgp.org.au</a>

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

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

#### How to apply for vocational recognition

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

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

**GPO Box 9848** 

CANBERRA ACT 2601

email address: gprac@health.gov.au

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

Continued vocational recognition is dependent upon:

- (a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and
- (b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

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

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

#### Removal of vocational recognition status

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

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

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

#### GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

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

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

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

#### **GN.5.15 Emergency Medicine**

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

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

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

#### **GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians**

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

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services. Information about the form of a diagnostic imaging request can be found in **Note IN.0.1** of the Diagnostic Imaging Services Table (Category 5) and information about the form of a pathology request can be found in **Note PN.2.1** of the Pathology Services Table (Category 6).

#### 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 their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);

- (ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
- (iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

- (a) sub-paragraphs (i), (ii) and (iii) do not apply to
- a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);
- (b) sub-paragraphs (ii) and (iii) do not apply to
- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and
- (c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

#### **Examination by Specialist Anaesthetists**

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

#### Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

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

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

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

#### **Billing**

#### Routine Referrals

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

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

#### Special Circumstances

#### (i) Lost, stolen or destroyed referrals.

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

#### (ii) Emergencies

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

#### (iii) Hospital referrals.

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

#### **Public Hospital Patients**

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

#### **Bulk Billing**

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

#### Period for which Referral is Valid

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

#### Specialist Referrals

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

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

#### Referrals by other Practitioners

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

#### **Definition of a Single Course of Treatment**

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

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

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

However, where the referring practitioner:-

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

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

#### **Retention of Referral Letters**

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

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

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

#### Attendance for Issuing of a Referral

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

#### **Locum-tenens Arrangements**

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

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

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

#### Self Referral

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

#### **GN.7.17 Billing procedures**

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

#### **Bulk** billing

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

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

Where the patient is bulk billed, an additional charge can **only** be raised against the patient by the practitioner where the patient is provided with a vaccine or vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items **3** to **96**, **179** to **212**, **733** to **789** and **5000** to **5267** (inclusive) and only relates to vaccines that

are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

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

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

#### GN.8.18 Provision for review of individual health professionals

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence:

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

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

#### **Additional Information**

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

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

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

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

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

#### **GN.8.19 Medicare Participation Review Committee**

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

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

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

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

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

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

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

#### **GN.8.21 Comprehensive Management Framework for the MBS**

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

#### **GN.8.22 Medical Services Advisory Committee**

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

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

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

#### **GN.8.23 Pathology Services Table Committee**

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

#### **GN.9.25 Penalties and Liabilities**

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

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

#### **GN.10.26 Schedule fees and Medicare benefits**

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

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

There are presently three levels of Medicare benefit payable:

- a. 75% of the Schedule fee:
  - i. for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '\*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'admitted' or 'in patient');
  - ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.
- b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner.
- c. 85% of the Schedule fee, or the Schedule fee less \$84.70 (indexed annually in November), whichever is the greater, for all other professional services.

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

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

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

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

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

#### **GN.10.27 Medicare safety nets**

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

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2020 is \$477.90. 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 2020, the threshold for singles and families that hold a Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is \$692.20. The threshold for all other singles and families in 2019 is \$2,169.20.

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

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

#### EMSN Benefit Caps:

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

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

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

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

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

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

#### **GN.11.28 Services not listed in the MBS**

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

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

#### **GN.11.29 Ministerial Determinations**

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

#### **GN.12.30 Professional services**

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

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

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

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

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

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

#### GN.12.31 Services rendered on behalf of medical practitioners

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

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

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

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

Supervision from outside of Australia is not acceptable.

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

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

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

#### **GN.12.32 Medicare benefits and vaccinations**

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

#### Example 1

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

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

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

#### Example 2

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

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

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

#### Example 3

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

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

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

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

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

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

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

#### Unless the Minister otherwise directs

Medicare benefits are not payable where:

- (a) the service is rendered by or on behalf of, or under an arrangement with the Australian Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;
- (b) the medical expenses are incurred by the employer of the person to whom the service is rendered;

- (c) the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- (d) the service is a health screening service.
- (e) the service is a pre-employment screening service

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

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

#### Pain pumps for post-operative pain management

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

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

#### **Non Medicare Services**

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

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

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

- (a) endoluminal gastroplication, for the treatment of gastro-oesophageal reflux disease;
- (b) gamma knife surgery;
- (c) intradiscal electro thermal arthroplasty;
- (d) intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
- (e) intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
- (f) low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;

- (g) lung volume reduction surgery, for advanced emphysema;
- (h) photodynamic therapy, for skin and mucosal cancer;
- (i) placement of artificial bowel sphincters, in the management of faecal incontinence;
- (j) selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
- (k) specific mass measurement of bone alkaline phosphatase;
- (1) transmyocardial laser revascularisation;
- (m) vertebral axial decompression therapy, for chronic back pain;
- (n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;
- (o) vertebroplasty;
- (p) extracorporeal magnetic innervation.

#### **Health Screening Services**

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

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

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

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

collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

- (e) a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;
- (f) a medical examination being a requisite for Social Security benefits or allowances;
- (g) a medical or optometrical examination provided to a person who is an unemployed person (as defined by the Social Security Act 1991), as the request of a prospective employer.

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

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

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

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

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

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

#### **GN.14.34 Principles of interpretation of the MBS**

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

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

#### GN.14.35 Services attracting benefits on an attendance basis

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

#### GN.14.36 Consultation and procedures rendered at the one attendance

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

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

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

#### **GN.14.37 Aggregate items**

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

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

#### GN.14.38 Residential aged care facility

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

#### GN.15.39 Practitioners should maintain adequate and contemporaneous records

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

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

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

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

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

clearly identify the name of the patient; and

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

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

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

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

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

## **CATEGORY 3: THERAPEUTIC PROCEDURES**

#### **SUMMARY OF CHANGES FROM 01/01/2020**

The 01/01/2020 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

#### **EMSN Amended**

13200	13201	13202	13203	13206	13209	13210	13212	13215	13218	13221	13251	16399
16400	16401	16404	16406	16500	16501	16502	16505	16508	16509	16511	16512	16514
16515	16518	16519	16520	16522	16527	16528	16531	16533	16534	16564	16567	16570
16571	16573	16590	16591	16600	16603	16606	16609	16618	16624	16627		

#### **Indexation of fixed EMSN caps**

MBS items with fixed caps in the Health Insurance (Extended Medicare Safety Net) Determination 2017 have had their caps increased. This change increases the caps of 13 capped items in the range 16603 to 82140 from 1 January 2020.

#### THERAPEUTIC PROCEDURES NOTES

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

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

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

#### TN.1.2 Haemodialysis - (Items 13100 and 13103)

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

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

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

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

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

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

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

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

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

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

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

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending either; not more than 30 days later, or if a service mentioned in item 13212, 13215 or 13221 is provided in connection with the series of treatments-on the day after the day on which the last of those services is provided.

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

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

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

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

#### TN.1.5 Intracytoplasmic Sperm Injection - (Item 13251)

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

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

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

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

### TN.1.6 Peripherally Inserted Central Catheters

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

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

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

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

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

# TN.1.8 Collection of Blood - (Item 13709)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### Items 13847 and 13848

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

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

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

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

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

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

#### Items 13870 and 13873

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

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

#### Item 13876

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

#### Item 11600

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

# TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13915)

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

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

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

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

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

Phototherapy should only be used when:

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

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

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

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

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

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

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

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

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

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

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

Items 14203 and 14206 are not payable for artificial insemination.

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

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

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

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

# TN.1.19 Immunomodulating Agent - (Item 14245)

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

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

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

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

- (a) A medical practitioner, or;
- (b) A specialist trainee under the direct supervision of a medical practitioner.
- (2) For paragraph (1) (b), a medical service provided by a specialist trainee is taken to have been provided by the supervising medical practitioner.
- (3) In this rule: Specialist trainee means a medical practitioner who is undertaking an Australian Medical Council (AMC) accredited Medical College Training Program. Direct Supervision means personal and continuous attendance for the duration of the service.

# TN.1.21 Telehealth Specialist Services

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

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

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

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

#### Clinical indications

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

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

# Restrictions

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

# Billing Requirements

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

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

### Eligible Geographical Areas

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

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

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

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

### Record Keeping

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

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

#### Extended Medicare Safety Net (EMSN)

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

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

### Aftercare Rule

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

#### Multiple attendances on the same day

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

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the same practitioner, provided the second (and any following) video consultations are not a continuation of the initial or

earlier video consultations. Practitioners will need to provide the times of each consultation on the patient's account or bulk billing youcher.

Referrals

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

Technical requirements

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

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

### TN.1.22 Cryopreservation of semen (Item 13260)

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

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

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

The purpose of item 13105 is for the management of haemodialysis to a person with end-stage renal disease. The service is provided in very remote areas (defined as Modified Monash 7) by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner. The service is supervised by a medical practitioner (either in person or remotely).

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

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

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

### TN.2.1 Radiation Oncology - General

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

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

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

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

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

In items 15275, 15555, 15565 and 15715:

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

In item 15275:

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

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

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

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

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

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

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

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

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

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

15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode. The IMRT simulation item (15555) and IMRT dosimetry item (15565) can only be billed in association with each other and only for IMRT (i.e. neither IMRT simulation item 15555, nor IMRT dosimetry item 15565, can be billed in association with any of the 2D or 3D treatment items for an episode of care).

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

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

In these items, 'treatment verification' means:

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

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

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

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

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

Items 15700, 15705, 15710 and 15715:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 16400 can only be claimed 10 times per pregnancy.

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

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

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

#### TN.4.3 Antenatal Care - (Item 16500)

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

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

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

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

Contraindications for this item are as follows:

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

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

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

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

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

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

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

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

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

# TN.4.6 Caesarean Section - (Item 16520)

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

#### TN.4.7 Complicated Confinement - (Item 16522)

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

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

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

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

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

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

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

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

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

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

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

Normal postnatal care by a medical practitioner would include:-

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

- (v) Rubella status and immunisation
- (vi) contraception advice/management

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

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

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

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

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

# TN.4.12 Telehealth Specialist Services

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

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

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

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

#### Clinical indications

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

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

#### Restrictions

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

#### Billing Requirements

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

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

#### Eligible Geographical Areas

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

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

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

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

### Record Keeping

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

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

# Extended Medicare Safety Net (EMSN)

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

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

# Aftercare Rule

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

Multiple attendances on the same day

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

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

#### Referrals

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

#### Technical requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- · Major cardiac problems e.g cardiomyopathy, unstable ischaemic heart disease, heart failure
- · Major respiratory disease e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,
- $\cdot$  Major neurological conditions CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS
- $\cdot$  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:**

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

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

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

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

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

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

#### **NOTE:**

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

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

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

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

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

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

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

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

# **TN.6.4 Telehealth Specialist Services**

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

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

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

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

#### Clinical indications

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

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

#### Restrictions

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

#### Billing Requirements

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

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

#### Eligible Geographical Areas

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

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

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

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

#### Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

#### Technical requirements

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

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

# TN.7.1 Regional or Field Nerve Blocks - General

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

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

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

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

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

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

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

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

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

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

This items covers caudal infusion/injection.

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

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

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

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

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

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

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

# **TN.8.1 Surgical Operations**

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

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

An explanation of each of these phrases is as follows.

# As an Independent Procedure

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

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

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

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

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

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

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

#### **TN.8.2 Multiple Operation Rule**

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

- 100% for the item with the greatest Schedule fee

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

plus 25% for each other item.

#### Note:

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

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

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

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

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

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

### Extended Medicare Safety Net Cap

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

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

#### TN.8.3 Procedure Performed with Local Infiltration or Digital Block

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

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

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

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

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

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

#### **Private Patients**

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

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

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

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

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

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

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

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

#### **Public Patients**

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

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

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

#### **Fractures**

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

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

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

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

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

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

# TN.8.5 Abandoned surgery - (Item 30001)

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

An operative procedure commences when:

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

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

Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from group T9. Such claims should include an account endorsement "assistance at abandoned surgery" or similar.

Under the Health Insurance Act 1973 the Chief Executive Medicare does not require claims for this item to be accompanied by details of the proposed surgery and the reasons why the operation was discontinued. However, practitioners must maintain a clinical record of this information, which may be subject to audit.

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

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

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

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

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

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

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

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

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

# TN.8.8 Lipectomy - (Items 30165 to 30179)

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

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

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

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

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

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

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

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

- (a) admission for treatment in an operating theatre of an accredited day surgery facility or hospital is required. In this circumstance, benefits are paid under item 30189 where a definitive removal of the wart or molluscum contagiosum is to be undertaken.
- (b) benefits have been paid under item 30189, and recurrence occurs.
- (c) palmar and plantar warts are treated by laser and require treatment in an operating theatre of an accredited day surgery facility or hospital. In this circumstance, benefits are paid under item 30187.

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

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

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

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

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

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

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

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

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

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

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

**Level I** - axillary lymph nodes up to the inferior border of pectoralis minor.

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

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

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

Anatomically, the dissection extends from below upwards as follows:

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

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

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

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

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

#### TN.8.16 Major Abdominal Incision - (Item 30396)

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

# TN.8.17 Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484, 30485, 30490 to 30494, 30680 to 32023, 32084 to 32095, 32103, 32104, 32106 and 32222 to 32229)

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

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

# Cleaning, disinfection and sterilisation procedures

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

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

#### Anaesthetic and resuscitation equipment

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

#### **Conjoint Committee**

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

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

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

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

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

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

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

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

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

For the purposes of these items the following definitions apply:

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

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

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

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

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

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

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

The excision of warts and seborrheic keratoses attracts benefits on an attendance basis with the exceptions outlined in TN.8.9 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31357, 31360, 31362, 31364, 31366, 31368 and 31370.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of  $40 \text{kg/m}^2$  or more, or a patient with a BMI of  $35 \text{kg/m}^2$  or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat

distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35-40 kg/m<sup>2</sup> provided for in the definition. The decision to undertake obesity surgery remains a matter for the clinical judgment of the surgeon.

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

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

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

TN.8.31 Per Anal Excision of Rectal Tumour using Rectoscopy - (Items 32103, 32104 and 32106) Surgeons performing these procedures should be colorectal surgeons and have undergone appropriate training which is recognised by the Colorectal Surgical Society of Australasia.

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

# TN.8.32 Varicose veins (Items 32500 to 32517) and Peripheral Arterial or Venous Embolisation (Item 35321)

Under the *Health Insurance (General Medical Services Table) Regulations*, items 32500 to 32517 and 35321 do not apply to services mentioned in those items if the services are delivered by:

- a. endovenous laser treatment (ELT); or
- b. radiofrequency diathermy; or
- c. radiofrequency ablation for varicose veins.

It is recommended that a practitioner who intends to bill ELT, radiofrequency diathermy or radiofrequency ablation for varicose veins on the same occasion as providing items 32500 to 32517 or 35321 contact the Department of Human Services' provider information line on 132 150 to confirm requirements for correct itemisation of services on a single invoice.

The Department of Health monitors billing practices associated with MBS items. Services for ELT, radiofrequency diathermy or radiofrequency ablation for varicose veins provided on the same occasion as items 32500 to 32517 or 35321 must be itemised separately on the invoice, showing the full fees for each service separately to the fees billed against these MBS items.

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

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

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

# TN.8.34 Uterine Artery Embolisation - (Item 35410)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## TN.8.42 Colposcopic Examination - (Item 35614)

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

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

## TN.8.43 Hysteroscopy - (Item 35626)

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

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

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

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

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

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

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

## TN.8.47 Debulking of Uterus - (Item 35658)

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

## TN.8.48 Nephrectomy - (Items 36526 and 36527)

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

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

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

## TN.8.51 Ureteroscopy - (Item 36803)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### TN.8.58 Transcutaneous Sperm Retrieval - (Item 37605)

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

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

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

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

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

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

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

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

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

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

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

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

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

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- electrocardiography (ECG) (items 1170-11702);
- echocardiography (items 55113-55115);
- continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);
- up-right tilt table test (item 11724); and
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

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

Item 38306 should only be billed once per occlusional site. It is not appropriate to bill item 38306 multiple times for the insertion of more than one stent at the same occlusional site in the same artery. However, it would be appropriate to claim this item multiple times for insertion of stents into the same artery at different occlusional sites or into

another artery or occlusional site. It is expected that the practitioner will note the details of the artery or site into which the stents were placed, in order for the Department of Human Services to process the claims.

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

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

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

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

#### TN.8.65 Cardiac Resynchronisation Therapy - (Item 38371)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

#### **TN.8.73 Meatoplasty - (Item 41515)**

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

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

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

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

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

Services performed under item 41668 require admission to hospital.

## TN.8.76 Larynx, Direct Examination - (Item 41501)

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

## TN.8.77 Microlaryngoscopy - (Item 41858)

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

#### TN.8.78 Imbedded Foreign Body - (Item 42644)

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, benefits are payable under the relevant attendance item.

## TN.8.79 Corneal Incisions - (Item 42672)

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

### TN.8.80 Cataract surgery (Items 42698 and 42701)

Items 42698 and 42701 provide for intraocular lens extraction and replacement as a separate procedure to be used in instances when lens removal and replacements are contraindicated at the same operation, such as in patients presenting with proliferative diabetic retinopathy or recurrent uveitis.

#### TN.8.81 Posterior Juxtascleral Depot injection - (Item 42741)

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

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

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

## TN.8.83 Insertion of drainage device for glaucoma (Item 42752)

Item 42752 provides for the insertion of a drainage device for the treatment of glaucoma patients who are at high risk of failure of trabeculectomy (such as patients who have aggressive neovascular glaucoma or extensive conjunctival scarring); have iridocorneal endothelial syndrome; inflammatory (uveitic) glaucoma; or aphakic glaucoma.

## TN.8.84 Laser Trabeculoplasty - (Item 42782)

Item 42782 is restricted to a maximum of 4 treatments in a 2 year period.

#### TN.8.85 Laser Iridotomy - (Item 42785)

Item 42785 is restricted to a maximum of 3 treatments in a 2 year period.

#### TN.8.86 Laser Capsulotomy - (Items 42788)

Item 42788 is restricted to a maximum of 2 treatments in a 2 year period.

## TN.8.87 Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Item 42791)

Item 42791 is restricted to a maximum of 3 treatments in a 2 year period.

#### TN.8.88 Division of Suture by Laser - (Item 42794)

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

## TN.8.89 Ophthalmic Sutures - (Item 42845)

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

## TN.8.91 Abrasive Therapy/Resurfacing - (Items 45021 to 45026)

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for benefits under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel<sup>®</sup>) laser therapy.

#### **TN.8.92 Escharotomy - (Item 45054)**

Benefits are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

#### TN.8.93 Local Skin Flap - Definition

Medicare benefits for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures.

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 45201, claimable once per defect. Additional flaps are to be claimed under Item 45202, if clinically indicated.

Note: refer to T8.128 for MBS item 45202 for circumstances where other services might involve flap repair.

## TN.8.94 Free Grafting to Burns - (Items 45406 to 45418)

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

## TN.8.95 Revision of Scar - (Items 45506 to 45518)

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31206 to 31225 should be claimed.

## TN.8.96 Augmentation Mammaplasty - (Items 45524, 45527 and 45528)

A Medicare benefit is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast sometime after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammaplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

#### TN.8.97 Breast Reconstruction, Myocutaneous Flap - (Item 45530)

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165-30179 (lipectomy items) should not be claimed in association with item 45530 as stated in the Health Insurance (General Medical Services Table) Regulations.

## TN.8.98 Breast Prosthesis, Removal and Replacement of - (Items 45553 and 45554)

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45553-45554 where the procedure is performed solely to increase breast size.

Where the original implant was not inserted in the context of breast cancer or developmental abnormality, intraoperative photographs need to demonstrate significant evidence of substantial skin laxity to justify replacement of the prosthesis.

In the context of eligibility for item 45553 and 45554, an unacceptable deformity would not include asymmetry caused as a result of implant removal.

Where a rupture has been established through imaging and reported, items 45553 and 45554 will still apply even if intra-operatively the implant is found to be structurally intact.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

## TN.8.99 Breast Ptosis - (Items 45556 and 45558)

For the purposes of item 45556, Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, in the context of breast cancer or developmental breast abnormality to match the position of the contralateral breast. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

Item 45558 applies where correction of breast ptosis is indicated because at least two-thirds of the breast tissue, including the nipple, lies inferior to the infra-mammary fold where the nipple is located at the most dependent, inferior part of the breast contour.

Full clinical details must be documented in patient notes, including pre-operative photographic evidence (including anterior, left lateral and right lateral views) as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

#### TN.8.100 Nipple and/or Areola Reconstruction - (Items 45545 and 45546)

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

## TN.8.101 Liposuction - (Items 45584 and 45585)

Medicare benefits for liposuction are generally attracted under item 45584, that is for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of Barraquer-Simons Syndrome, lymphoedema or macrodystrophia lipomatosa, or the reduction of buffalo hump, item 45585 applies. One regional area is defined as one limb or trunk. If liposuction is required on more than one limb, item 45585 can be claimed once per limb.

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

#### TN.8.102 Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)

Benefits are payable under items 45587 and 45588 for face lift operations performed in hospital to correct soft tissue abnormalities of the face due to causes other than the ageing process, including trauma, a congenital condition or disease.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies.

Full clinical details must be documented in patient notes, including pre-operative photographic and/or diagnostic imaging evidence demonstrating the clinical need for the service as this may be subject to audit.

## TN.8.103 Reduction of Eyelids - (Items 45617 and 45620)

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits.

Medicare benefits are not payable for non-therapeutic cosmetic services. Full clinical details must be documented in patient notes, including clear photographic evidence of the loss of visual field, evidenced by eyelid skin prolapsing over the lashes in a relaxed straight-ahead gaze. The clinical need for the service must be demonstrated as this may be subject to audit.

#### TN.8.104 Rhinoplasty - (Items 45632 to 45644, and 45650)

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

A Medicare benefit for items 45632 – 45644 and 45650 is payable where the indication for surgery is for:

- (i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or
- (ii) significant acquired, congenital or developmental deformity.

The NOSE Scale refers to the Nasal Obstruction Symptom Evaluation Scale, developed by Stewart et al, as published in the Otolaryngology-Head and Neck Surgery, 130: 2.

The NOSE Scale can be accessed here: https://www.entnet.org//content/facial-plasticsrhinology-outcome-tool-nose-scale

Full clinical details must be documented in patient notes, including pre-operative photographic and / or NOSE Scale evidence demonstrating the clinical need for the service as this may be subject to audit.

## TN.8.105 Contour Restoration - (Item 45647)

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

## TN.8.106 Vermilionectomy - (Item 45669)

Item 45669 covers treatment of the entire lip.

## TN.8.107 Osteotomy of Jaw - (Items 45720 to 45752)

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

#### TN.8.108 Genioplasty - (Item 45761)

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

#### TN.8.109 Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)

It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

#### TN.8.110 Fracture of Mandible or Maxilla - (Items 45975 to 45996)

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

#### TN.8.111 Reduction of Dislocation or Fracture

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

#### TN.8.112 Removal of Multiple Exostoses (Items 47933 and 47936)

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

## TN.8.116 Wrist Surgery - (Items 49200 to 49227)

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

## TN.8.117 Diagnostic Arthroscopy and Arthroscopic Surgery of the Knee (Items 49557 and 49563)

The Medical Services Advisory Committee (MSAC) evaluated the available evidence and did not support public funding for matrix-induced autologous chondrocyte implantation (MACI) or autologous chondrocyte implantation (ACI) for the treatment of chondral defects in the knee and other joints, due to the increased cost compared to existing procedures and the lack of evidence showing short term or long-term improvements in clinical outcomes. Medicare benefits are not payable in association with this technology.

#### **TN.8.118 Paediatric Patients - (Items 50450 to 50658)**

For the purpose of Medicare benefits a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

#### TN.8.119 Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Medicare benefits are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

# TN.8.120 Unresectable primary malignant tumour of the liver destruction of by open or laparoscopic radiofrequency ablation or microwave tissue ablation- (Item 50952)

A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

## TN.8.121 Paracentesis of anterior chamber or vitreous cavity and/or intravitreal injection - (Items 42738 to 42740)

Items 42738 and 42739 provide for paracentesis for the injection of therapeutic substances and/or the removal of aqueous or vitreous, when undertaken as an independent procedure. That is, not in conjunction with other intraocular surgery.

Item 42739 should be claimed for patients requiring anaesthetic services for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical

anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

- nystagmus or eye movement disorder;
- cognitive impairment precluding safe intravitreal injection without sedation;
- a patient under the age of 18 years;
- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or
- endophthalmitis or other inflammation requiring more extensive anaesthesia (eg peribulbar).

Practitioners billing item 42739 must keep clinical notes outlining the basis for the use of anaesthetic.

Item 42740 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery including with a service to which Item 42809 (retinal photocoagulation) applies.

#### TN.8.122 Bone Graft (Items 48200-48242 and 48642-48651)

Bone graft substitute materials can be used for the purpose of bone graft for items 48200-48242 and 48642-48651.

#### TN.8.123 Vulvoplasty and Labioplasty - (Items 35533 and 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation or a major congenital anomaly of the uro-gynaecological tract which is not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for a structural abnormality causing significant functional impairment and is restricted to patients aged 18 years and over.

A detailed clinical history outlining the structural abnormality and the medical need for surgery of the vulva and/or labia must be included in patient notes, as this may be subject to audit.

Medicare benefits are not payable for non-therapeutic cosmetic services.

## TN.8.124 Treatment of Wrist and Finger Fractures - (Items 47301 to 47319, and 47361 to 47373)

- For the purposes of these items, fixation includes internal and external.
- Regarding item 47362, major regional anaesthesia includes bier block.

## TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31376)

The necessary excision diameter (or defect size) refers to the lesion size plus a clinically appropriate margin of healthy tissue required with the intent of complete surgical excision. Measurements should be taken prior to excision. Margin size should be determined in line with NHMRC guidelines:

Clinical practice guide - Basal cell carcinoma, squamous cell carcinoma(and related lesions)-a guide to clinical management in Australia. November 2008. Cancer Council Australia and; Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand (2008).

For the purpose of Items 31356 to 31376 the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: <u>Determining lesion size for MBS item selection</u>.

Practitioners must retain copies of histological reports and any other supporting evidence (patient notes, photographs etc). Photographs should include scale.

An episode of care includes both the excision and closure for the same defect, even when excision and closure occur at separate attendances.

Definitive surgical excision for items 31371 to 31376 means surgical removal with adequate margins as part of the curative management of the malignancies specified in these items.

An incomplete surgical excision of a malignant skin lesion with curative intent should be billed as a malignant skin lesion excision item even when further surgery is needed. Wide excision of the primary tumour bed following local excision of a primary melanoma, appendageal carcinoma, malignant connective tissue or merkel cell carcinoma of the skin may be claimed using item 31371, 31372, 31373, 31374, 31375 or 31376, depending on the location of the malignancy and the size of the excision diameter.

For Items 31356 to 31370, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

### TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous witha free margin).

Clinical evidence may be supported by patient notes, photographs of the affected area and pathology reports.

# TN.8.127 Interpretation of femoroacetabular impingement (FAI) restriction (items 48424, 49303,49366)

Patients presenting with hip dysplasia, Perthes Disease and Slipped Upper Femoral Epiphysis (SUFE) are eligible for treatment under items 49366, 49303 and 48424.

# TN.8.132 Transcatheter occlusion of left atrial appendage for stroke prevention (item 38276) Explanatory Note

A contraindication to lifelong anticoagulation is defined as:

- i) a previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy,
- ii) a blood dyscrasia, or
- iii) a vascular abnormality predisposing to potentially life threatening haemorrhage

The procedure is performed as a hospital service.

#### TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

Endoscopic upper GI stricture services 41819 and 41820 have been consolidated under item 30475. This consolidated item will allow any endoscopic technique to be performed for oesophageal through to gastroduodenal procedures and will include imaging intensification if done. The fee is the same as item 41819 which higher than item 30475 but lower than 41820.

## TN.8.134 Application of items 32084, 32087, 32090 and 32093

If a service to which item 32084, 32087, 32090 or 32093 applies is provided by a practitioner to a patient on more than one occasion on a day, the second service is taken to be a separate service for the purposes of the item if the second service is provided under a second episode of anaesthesia or other sedation.

#### TN.8.135 Transcatheter Aortic Valve Implantation (Item 38495)

Item 38495 applies only to a service for Transcatheter Aortic Valve Implantation (TAVI) for the treatment of symptomatic severe aortic stenosis, that is to be provided in a TAVI Hospital by a TAVI Practitioner on a TAVI patient.

#### **TAVI Hospital**

For item 38495 a TAVI Hospital means a hospital, as defined by subsection 121-5(5) of the Private Health Insurance Act 2007, that is clinically accepted as being a suitable hospital in which the service described in Item 38495 may be performed.

The Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners developed by Cardiac Accreditation Services Limited provides guidance on what are considered by the sector as minimum requirements that must be met in order to be a clinically acceptable facility that is suitable for TAVI procedures to be performed at.

Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners can be accessed via www.tavi.org.au.

#### **TAVI Practitioner**

For item 38495 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules* for the Accreditation of TAVI Practitioners, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, www.tavi.org.au.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

#### **TAVI Patient**

A TAVI Patient means a patient who, as a result of a TAVI Case Conference, has been assessed as having an unacceptably high risk for surgical aortic valve replacement and is recommended as being suitable to receive the service described in item 38495.

A TAVI Case Conference is a process by which:

- (a) there is a team of 3 or more participants, where:
  - (i) the first participant is a cardiothoracic surgeon; and

- (ii) the second participant is an interventional cardiologist; and
- (iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and
  - (iv) either the first or the second participant is also a TAVI Practitioner; and
- (b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:
  - (i) the patient's risk and technical suitability for a surgical aortic valve replacement; and
  - (ii) the patient's cognitive function and frailty; and
- (c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and
- (d) the particulars of the assessment and recommendation are recorded in writing.

While benefits are payable for an eligible TAVI Case Conference under Items 6080 and 6081, a claim for these services does not have to be made in order for a benefit to be paid under Item 38495. Item 38495 is only payable once per patient in a five year period.

## TN.8.136 Corneal Collagen Cross Linking (Item 42652)

Evidence of progression in patients over the age of twenty five is determined by the patient history including an objective change in tomography or refraction over time. Evidence of progression in patients aged twenty five years or younger is determined by patient history including an objective change in tomography or refraction over time and/or posterior elevation data and objective documented progression at a subclinical level.

### TN.8.137 Thyroidectomy and hemithyroidectomy procedures (items 30296, 30306, and 30310)

Total thyroidectomy or total hemithyroidectomy are the most appropriate procedures in the majority of circumstances when a thyroidectomy is required. The preferred procedure for thyrotoxicosis is total thyroidectomy (item 30296). Item 30310 is to be used only in uncommon circumstances where a subtotal or partial thyroidectomy is indicated and includes a subtotal lobectomy, nodulectomy, or isthmusectomy or equivalent partial thyroidectomy.

## TN.8.138 Re-exploratory thyroid surgery (item 30297)

Item 30297 is for re-exploratory thyroid surgery where prior thyroid surgery and associated scar tissue increases the complexity of surgery. For completion hemithyroidectomy on the contralateral side to a previous hemithyroidectomy for thyroid cancer, item 30306 is the appropriate item.

## TN.8.139 Personal performance of a Synacthen Stimulation Test (item 30097)

A 0900h serum cortisol (0830-0930) less than 100 nmol/L indicates adrenal deficiency and a Synacthen Test is not required.

A 0900h serum cortisol (0830-0930) greater than 400 nmol/L indicates adrenal sufficiency and a Synacthen Test is not required. An exception to this is when testing women on oral contraception where cortisol levels may be higher due to increases in cortisol-binding globulin and this threshold may not exclude women with adrenal insufficiency.

## TN.8.140 Excision of graft material - Items 35581 and 35582

For items 35581 and 35582 the size of the excised graft material must be histologically tested and confirmed.

## TN.8.141 Application of items 51011 to 51171 (Sub-group 17)

Spinal surgery items 51011 to 51171 cannot be performed in conjunction with any other item (outside of subgroup 17) in Group T8 of the MBS (surgical operation items 30001 to 50952), when that surgical item is related to spinal surgery. Items 50600 to 50644 - spine surgery for scoliosis and kyphosis in paediatric patients - are excepted from this rule when claimed in conjunction with items 51113 and 51114.

#### Meaning of Motion Segment

Motion segment is defined as including all anatomical structures (including traversing and exiting nerve roots) between and including the top of the pedicle above to the bottom of the pedicle below.

#### Combined Anterior and Posterior Surgery

Combined anterior/ posterior surgery items 51061, 51062, 51063, 51064, 51065 and 51066 cannot be claimed with any item between 51020 and 51045 (i.e. items for spinal instrumentation, posterior bone graft and/or anterior column fusion).

#### Interpretation of Spinal Fusion

Lumbar spinal fusion may not be claimed for chronic low back pain for which a diagnosis has not been made.

#### TN.8.142 Spinal Decompression - Items 51011 to 51015

Items 51011 to 51015 are for services which include discectomy, decompression of central spinal canal by laminectomy or partial corpectomy (vertebral spurs and osteophytes; less than 50% of the vertebral body), and decompression of the subfacetal recess, the exit foramen and far lateral (intertransverse) space.

For decompression procedures, only one item is selected from 51011 to 51015.

For posterolateral spinal fusion without instrumentation, if a decompression procedure is combined with the fusion, two items numbers can be selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers can be selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items can be selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers can be selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

If more than 50% of a vertebral body is resected (piecemeal vertebrectomy) an item from 51051 to 51059 can be selected in addition to an item from 51011 to 51015.

Items 51011 to 51015 can be used when the purpose of the laminectomy is exposure or posterior spinal release.

#### TN.8.143 Spinal Instrumentation (cervical, thoracic and lumbar) - Items 51020 to 51026

Items 51020 to 51026 are intended for spinal instrumentation at any level. The appropriate item is determined by the number of motion segments instrumented, barring item 51020 which applies to one vertebra.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

# TN.8.144 Posterior and/or Posterolateral (intertransverse or facet joint) bone graft (cervical, thoracic and lumbar) - Items 51031 to 51036

Items 51031 to 51036 are for services which include local morcellized, artificial or harvested bone graft with or without bone morphogenic protein (BMP).

For posterolateral spinal fusion without instrumentation, if a decompression is combined with the fusion, two items numbers are selected: one from 51011 to 51015 and one from 51031 to 51036.

For posterolateral spinal fusion with instrumentation, two item numbers are selected: one from 51020 to 51026 and one from 51031 to 51036. If decompression is also performed, three items are selected: one from 51011 to 51015, one from 51020 to 51026 and one from 51031 to 51036.

For instrumental spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

## TN.8.145 Anterior column fusion, with or without implant, or limited vertebrectomy (less than 50%) and anterior fusion (cervical, thoracic and lumbar) - Items 51041 to 51045

Items 51041 to 51045 are for services which include placement of local morcellized, artificial, harvested bone graft, bone morphogenic protein (BMP) and prosthetic devices into the invertebral space. Artificial bone grafting materials must be used in accordance with the manufacturer's instructions.

Items 51041 to 51045 are to be selected irrespective of surgical approach (anterior, direct lateral or posterior via open or minimally invasive techniques).

For instrumented spinal fusion with interbody and posterolateral bone graft (with or without cages) and decompression, four item numbers are selected: one from one from 51011 to 51015, one from 51020 to 51026, one from 51031 to 51036 and one from 51041 to 51045.

For and instrumented anterior cervical decompression and fusion, (with or without cage) three items are selected: one from 51011 to 51015, one from 51020 to 51026, and one from 51041 to 51045.

Items 51041 to 51045 cannot be claimed with any item between 51051 and 51059 if performed at the same motion segment.

If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item from outside the spinal surgery schedule.

## TN.8.146 Spinal Osteotomy and/or vertebrectomy - Items 51051 to 51059

Items 51051 to 51059 are intended for spinal osteotomy and/or vertebrectomy at any level.

For the purpose of items 51054, 51055 and 51056, the definition of piecemeal or subtotal excision is the removal of at least 50% of the vertebral body.

Items 51051 to 51059 cannot be claimed with any item between 51041 and 51045 if performed at the same motion segment.

## TN.8.147 Anterior and Posterior (combined) Spinal fusion under one anaesthetic via separate incisions - Items 51061 to 51066

Only one of these items should be billed for any appropriate combined anterior and posterior surgeries which are completed under one anaesthetic. The appropriate item is determined by the number of motion segments to which grafting and fusion occur.

These items cannot be claimed with any item between 51020 to 51026, 51031 to 51036 and 51041 to 51045.

If a laminectomy is included, an item from 51011 to 51015 can also be used appropriate to the level of decompression.

If spinal osteotomy or vertebrectomy (>50%) is performed as part of the combined anterior/posterior approach, it is appropriate to claim one item between 51051 to 51056 in addition to an item between 51061 to 51066.

#### TN.8.148 Odontoid Screw fixation - Item 51103

This item is not for use when another item is claimed for the management of the odontoid fracture.

#### TN.8.149 Application of items 51160 and 51166

If the spine surgeon performs their own exposure to the thoracic or lumbar spine then 51160 or 51165 can be added to the claim for the overall surgery. If an assisting surgeon is used at any time during the procedure, then 51160 or 51165 should be used in isolation by the assisting surgeon. If the assisting surgeon needs to perform complex non-spinal surgery, they may use a more appropriate item but not in combination with 51160 or 51165. If an exposure surgeon claims a number from any section of the MBS schedule, the spinal surgeon cannot claim 51160 or 51165.

#### TN.8.150 Correction of Developmental Breast Abnormality - (Items 45060 to 45062)

Full clinical details must be documented in patient notes, including pre-operative photographic and / or diagnostic imaging evidence as specified in the item descriptor which demonstrates the clinical need for the service, as this may be subject to audit.

Volumetric measurement of the breasts should be performed using a technique which has been reported in a published study.

## TN.8.151 Mohs surgery service caseload

Services under items 31000, 31001 and 31002 should make up at least 90% of a Mohs surgeon's caseload of items 31000-31005 annually.

## TN.8.152 Colonoscopy Items (items 32222-32229)

## Colonoscopy items (items 32222-32229)

It is expected that clinicians using the MBS items for colonoscopy also refer to national guidelines such as the National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines for Surveillance Colonoscopy (NHMRC guidelines). For more information on clinical practice guidelines for surveillance colonoscopy see the colorectal cancer pages on the <u>Cancer Council Australia website</u>.

Surveillance colonoscopy should be planned based on high-quality endoscopy in a well-prepared colon using most recent and previous procedure information when histology is known. Clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient.

The NHMRC guidelines do not support the use of colonoscopy for patients at average or slightly above average risk of colorectal cancer who do not have symptoms or a positive faecal occult blood test (FOBT).

Items 32222-32228 specify that there is endoscopic examination to the caecum. The 'to the caecum' requirements for colonoscopy examinations do not apply to patients who have no caecum following right hemi colectomy. For these patients the examination should be to the anastomosis. Item 32084 should be billed if preparation is inadequate to allow visualisation to the caecum.

General practitioners should ensure colonoscopy referral practices align with applicable national guidelines, including the Royal Australian College of General Practitioners' guidelines for preventive activities in general practice (the red book). In addition, general practitioners are urged to recommend biennial FOBT screening to age-appropriate patients.

## Colonoscopy where a polyp/polyps are removed

Items 32222-32226 and 32228 provide for diagnostic colonoscopy when claimed alone. Where a polyp or polyps are removed during the colonoscopy, item 32229 should also be claimed in association with the appropriate colonoscopy item.

#### **Definition of previous history (items 32222-32225)**

For items 32223-32225 the most appropriate item to be billed is determined by the previous history of the patient. The previous history for the purpose of these items is defined by number, size and type of adenomas removed during any previous colonoscopy.

Although with a patient with a previous history of 1-2 low risk adenomas (<10mm with no high-risk histological features) is eligible for a colonoscopy every five years under item 32223, clinical guidlines indicate that colonoscopy every 10 years is sufficient.

## Definition of moderate risk of colorectal cancer due to family history (item 32223)

For item 32223 a patient is considered at moderate risk of colorectal cancer if there is moderate risk family history of colorectal cancer – defined as:

- 1 first degree relative less than 55 years of age at diagnosis; OR
- 2 first degree relatives with a history of colorectal cancer; OR
- 1 first degree relative and 2 second degree relatives with a history of colorectal cancer.

The national clinical practice guidelines support the use of FOBT as a first line test for patients with a low risk family history of colorectal cancer.

#### Exception item (item 32228)

Timing of colonoscopy following polypectomy should conform to the recommended surveillance intervals set out in clinical guidelines, taking into account individualised risk assessment. In the absence of reliable clinical history, clinicians should use their best clinical judgement to determine the interval between testing and the item that best suits the condition of the patient. Where the clinician is unable to access sufficient patient information to enable a colonoscopy to be performed under items 32222-32226, but in their opinion there is a clinical need for a colonoscopy, then item 32228 should be used. This item is available once per patient per lifetime.

#### Time intervals

Items 32223, 32224, 32225 and 32226 have time intervals for repeat colonoscopy which are consistent with guidelines. These services are payable under Medicare only when provided in accordance with the approved intervals.

Patients may fit several categories and the most appropriate fit is a matter for clinician judgement with the highest risk indicating what subsequent colonoscopy intervals are appropriate. The examples provided below show that the result of the histopathology will not lengthen the surveillance intervals (in the case of patient with familial adenomatous polyposis (FAP) or Lynch syndrome) and may actually shorten the surveillance intervals.

#### Example 1

A patient at high risk of colorectal cancer with FAP or Lynch syndrome has a number of polyps removed at a surveillance colonoscopy. Item 32226 and 32229 are the appropriate items to bill. If the histology result returns 1-2 adenomas for patients at low to moderate risk then the next surveillance colonoscopy is recommended in 5 years. However, the patient's familial condition means that a shorter interval (12 months) is recommended and payable.

#### Example 2

A patient at moderate risk of colorectal cancer because of family history has a number of polyps removed at a surveillance colonoscopy. Item 32223 and 32229 are the appropriate items to bill based on the patient's family history. If the histology testing returns showing an adenoma with high-risk histological features then the next surveillance colonoscopy is recommended in 3 years instead of 5 years.

## How to use the items with new patients who have undergone previous colonoscopy

Patients whose care continues within one practice should have the relevant history readily available to guide decision making. For new patients, practitioners should make reasonable efforts to establish a patient's previous colonoscopy history. This includes seeking information from My Health Record, the records department of the hospital where the previous procedure occurred, the GP or the patient. The patients' MBS claims history for colonoscopy services will also assist with this.

For audit purposes it is important to record the most appropriate item. In accordance with good practice, clinicians are required to maintain records that include pathology results which must be made available to the patient or other practitioners as required.

The Australian Commission on Safety and Quality in Health Care's <u>Colonoscopy Clinical Care Standard</u> states all facilities and clinicians delivering colonoscopy services must provide a timely copy of the colonoscopy report and histology result to the patient and their GPs. Compliance with the Colonoscopy Clinical Care Standard is mandatory under the Australian Health Service Safety and Quality Accreditation Scheme.

## Patient eligibility for colonoscopy services

The Department of Human Services (DHS) will be able to confirm whether a colonoscopy service has been claimed by an individual patient and the date of service. It will also be able to confirm any restriction on the frequency of the item claimed which would prevent a rebate from being paid if the service was provided again within the restricted period. Patients can seek clarification from the DHS by calling 132 011.

Patients can also access their own claiming history with a My Health Record or by establishing a Medicare online account through <u>myGov</u> or the Express Plus Medicare mobile app.

Further information about these services can be found on the Department of Human Services website.

Practitioners providing colonoscopy services can call Medicare on **132 150** to check the patient's claiming history. The patient's Medicare card number will be required together with the range of item numbers to be checked. For example, the new item numbers for colonoscopy services are in the range 32222-32229. The operator will interrogate the patient's claiming history and provide advice on any claims paid for a colonoscopy service within the range of items specified and the date of the service.

Providers can also check a patient's eligibility via <u>Health Professional Online Services</u> (HPOS). HPOS will be able to return advice on whether a service is payable or not payable.

All patients who require a colonoscopy will be eligible for a service. However, MBS rebates will not be payable for services which do not meet the clinical indications and the item requirements for a colonoscopy or a repeat colonoscopy where the interval is specified in the item. Practitioners should ensure that their practice conforms to the approved clinical guidelines.

The DHS enquiry lines for providers and for patients is available 24 hours a day, seven days a week. Further information about these services can be found on the Department of Human Services website.

#### TN.9.1 Assistance at Operations - (Items 51300 to 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

**NOTE:** The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

## **Assistance at Multiple Operations**

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

<b>Multiple Operation Rule - Surgeon</b>	<b>Multiple Operation Rule - Assistant</b>
Item A - \$300@100%	Item A (Assist.) - \$300@100%
Item B - \$250@50%	Item B (No Assist.)
Item C - \$200@25%	Item C (Assist.) - \$200@50%
Item D - \$150@25%	Item D (Assist.) - \$150@25%

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

## **Surgeons Operating Independently**

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

## TN.9.2 Benefits Payable under Item 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

## TN.9.3 Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

## TN.9.4 Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

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

## TN.9.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

## TN.10.1 Relative Value Guide For Anaesthetics - (Group T10) Overview of the RVG

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Department of Human Services website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the MBS fee for anaesthesia in connection with a procedure is comprised of up to three components:

- 1. The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997);
- 2. The time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136); and
- 3. Where appropriate, modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020).

#### Assistance at anaesthesia

To establish the fee for the assistant service items 25200 and 25205, both services have been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers as appropriate to determine the MBS fee.

## Whole body perfusion

Where whole body perfusion is performed, the MBS fee is determined by adding together the following:

- 1. The base units allocated to the service (item 22060);
- 2. The time unit allocation reflecting the total time of the perfusion (an item in the range 23010 24136); and
- 3. Where appropriate, modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 25020).

## **TN.10.2 Eligible Services**

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. An "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee.

## TN.10.3 RVG Unit Values

#### **Basic Units**

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

#### **Time Units**

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- for anaesthesia, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- for assistance at anaesthesia, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- for perfusion, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

#### 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 aged not more than 3 years or at least 75 years (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).

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.

<sup>\*</sup> 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.

#### Definition of Emergency

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

## Definition of After Hours

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

#### TN.10.4 Deriving the Schedule Fee under the RVG

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (Units x \$20.10)
20840	Anaesthesia for resection of perforated bowel	6	\$120.60
23200	Time - 4 hours 40 minutes		\$482.40
25000	Modifier - Physical sttaus		\$20.10
22012	2 Central Venous Pressure Monitoring		\$60.30
	TOTAL	34	\$683.40

### **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 \$20.10)
20840	Anaesthesia for resection of perforated bowel	6	\$120.60
23200	Time - 4 hours 40 minutes	24	\$482.40
25000	Modifier - Physical status	1	\$20.10
22012	Central Venous Pressure Monitoring	3	\$60.30
	TOTAL	34	Schedule fee = \$683.40
25025	Anaesthesia After Hours Emergency Modifier		Schedule Fee \$683.40 x 50% = \$341.70

#### **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 open Cholecystectomy	8	\$160.80
20752	Incisional Hernia	6	(lower value than 20790 = 20752 schedule fee not payable) \$120.60
23111	Time - 2hrs 30mins	11	\$221.10
25015	Physical Status - Over 75	1	\$20.10
	TOTAL	20	\$402.00

## **Prolonged Anaesthesia**

Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

## TN.10.5 Minimum Requirements for Claiming Benefits under Items in the RVG (including sedation)

Medicare benefits for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists.

#### Staffing

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

#### **Facilities**

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;
- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

#### **TN.10.6 Account Requirements**

Before a benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out in the General Explanatory Notes of the Medicare Benefits Schedule are required on the anaesthetist's account:

- the anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- the assistant anaesthetist's account must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic
- the perfusionist's account must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

#### **TN.10.7 General Information**

The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.8).

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 26 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 TN.7.1. 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 the same medical practitioner, 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 items 18216 or 18219 (18226 and 18227 for afer hours) 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.

For the purposes of items 18216 and 18226, one attendance means that the medical practitioner cannot claim either of these items if the additional attendance is to optimise the initial treatment. Optimise means extension or improvement in analgesic quality of an existing block, without the insertion of a new block as a separate procedure.

#### TN.10.8 Additional Services Performed in Connection with Anaesthesia - Subgroup 19

Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as blood pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22031-22042)) 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.

## Items 22012, 22014 and 22025

A patient who is categorised as having a high risk of complications is one where clinical indications allow for the following items to be claimed (in conjunction with items 22012, 22014 and 22025) with item 25000, item 25005 or item 25010 modifiers, and/or item 25015, and/or items 25020, 25025 and/or when the basic surgical item value is 10 or more units, and/or is conjunction with items in group T10 Subgroup 13 (Shoulder and Axilla), or with items 23170 - 24136 (for procedures of greater than four hours duration) noting this is not an exhaustive list.

## Item 22042

This item can be co-claimed with item 20142 (anaesthesia for lens surgery), when anaesthesia or sedation was also provided by the same anaesthetist.

Item 22042 cannot be co-claimed with item 20142, 20144, 20145 and 20147 when a general anaesthetic is the primary anaesthetic approach.

#### TN.10.9 Assistance in the Administration of Anaesthesia

The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for Medicare benefits only where the same service is not also claimed by the primary anaesthetist.

#### Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

#### Assistance in the administration of elective anaesthesia (Item 25205)

A separate benefit is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:

- the need for invasive monitoring (intravascular or transoesophageal); or
- organ transplantation; or
- craniofacial surgery; or
- major tumour resection; or
- separation of conjoint twins.

## TN.10.10 Perfusion Services - (Items 22055 to 22075)

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

As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate, i.e.

(a) the basic units allocated to whole body perfusion under item 22060:

22060 **WHOLE BODY PERFUSION, CARDIAC BYPASS**, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (See para TN.10.10 of explanatory notes to this Category)

(b) plus, the time unit allocation reflecting the total time of the perfusion (an item in the range 23010 - 24136), for example:

23170 4:01 HOURS TO 4:10 HOURS (21 basic units)

plus, where appropriate

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

Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is not more than 3 years or at least 75 years (1 basic unit)

The time component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Item 22065 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 service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10.

The medical practitioner providing the service must comply with the training requirements in the Australian and New Zealand College of Anaesthetists *Guidelines for Major Extracorporeal Perfusion* (PS27).

Benefits are not payable if another person primarily and/or continuously operates the Heart Lung Machine.

## TN.10.12 Discontinued Procedure - (Item 21990)

Item 21990 applies when a patient has been anaesthetised but the proposed procedure has been abandoned prior to surgery commencing.

Claims should include notation of the surgery or procedure which had been proposed.

Under the Health Insurance Act 1973 the Chief Executive Medicare does not require claims for this item to be accompanied by details of the proposed surgery and the reasons why the operation was discontinued. However, practitioners must maintain a clinical record of this information, which may be subject to audit.

## TN.10.13 Anaesthesia in Connection with a Procedure not Identified as Attracting a Medicare Benefit for Anaesthesia - (Item 21997)

Payment of benefit for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

#### TN.10.14 Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

## TN.10.15 Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

# TN.10.16 Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of the Medicare Benefits Schedule)

Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG. Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

## TN.10.17 Nerve or Plexus Blocks for Post Operative Pain - (Items 22031 to 22041) Items 22031 to 22041

Benefits are only payable for intra-operative nerve or plexus blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22041.

#### Items 22031 and 22036

For items 22031 and 22036, postoperative pain management means that the injected therapeutic substance is expected to prolong the analgesic effect of the epidural or intrathecal technique.

#### Item 22031 (initial intrathecal or epidural injection)

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.

#### Item 22036 (subsequent intrathecal or epidural injection)

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.

#### Item 22041 (plexus or nerve block)

Benefits are payable under item 22041 in addition to the general anaesthesia for the related procedure.

#### TN.10.18 Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteoctomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

#### TN.10.22 Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

#### TN.10.23 Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

## TN.10.24 Anaesthesia for Femoral Artery Embolectomy - (Item 21274)

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

## TN.10.25 Anaesthesia for Cardiac Catheterisation - (Item 21941)

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

## TN.10.26 Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)

Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

### TN.10.27 Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and 7)

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

# TN.10.28 Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)

Benefits are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Benefits do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

## TN.10.29 Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911) Benefits are not payable under item 20911 for diagnostic ureteroscopy.

## TN.10.30 Credentialing for peri-operative cardiac ultrasound services (22051)

Item 22051 should be performed by a provider who is appropriately credentialed to provide the particular service, by a recognised body for the credentialing of peri-operative cardiac ultrasound services. Credentialing must be based on criteria consistent with those recommended by the Australian and New Zealand College of Anaesthetists in the current version of their Professional Document PS46 "Guidelines on Training and Practice of Perioperative Cardiac Ultrasound in Adults.

## TN.11.1 Botulinum Toxin - (Items 18350 to 18379)

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently three botulinum toxin agents with TGA registration (Botox®, Dysport® and

Xeomin®). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is recognised as an eligible medical practitioner for the relevant indication under the arrangements under Section 100 of the *National Health Act 1953* (the Act) relating to the use and supply of botulinum toxin. The specialist qualifications required to administer botulinum toxin vary across the indications for which the medicine is listed on the PBS, and are detailed within the relevant PBS restrictions available at: <a href="https://www.pbs.gov.au/browse/section100-mf">www.pbs.gov.au/browse/section100-mf</a>

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the PBS listing for the supply of the medicine for this indication under Section 100 of the *Act*.

Item 18362 for the treatment of severe primary axillary hyperhidrosis allows for a maximum number of 3 treatments per patient in a 12 month period, with no less than 4 months to elapse between treatments.

Botulinum toxin which is not supplied and administered in accordance with the arrangements under Section 100 of the *Act* is not required to be provided free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare. Since 1 September 2015, PBS patient co-payments have applied to botulinum toxin supplied and administered in accordance with the arrangements under Section 100 of the Act.

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

#### TR.8.1 Mechanical thrombectomy - (Item 35414)

For the purposes of this item, *eligible stroke centre* means a facility that:

- (a) has a designated stroke unit;
- (b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:
  - (i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;

- (ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and
- (iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;
- (c) has dedicated endovascular angiography facilities; and
- (d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

## Conjoint Committee for Recognition of Training in Interventional Neuroradiology (CCINR)

CCINR comprises representatives from the Australian and New Zealand Society of Neuroradiology (ANZSNR), the Neurosurgical Society of Australasia (NSA) and the Australian and New Zealand Association of Neurologists (ANZAN). For the purposes of this item, specialists or consultant physicians performing this procedure must have training recognised by CCINR, and the Department of Human Services notified of that recognition.

# THERAPEUTIC PROCEDURES ITEMS

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES  1. HYPERBARIC OXYGEN THERAPY		
	Group T1. Miscellaneous Therapeutic Procedures		
	Subgroup 1. Hyperbaric Oxygen Therapy		
	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance.		
13015	(See para TN.1.1 of explanatory notes to this Category) <b>Fee:</b> \$258.85 <b>Benefit:</b> 75% = \$194.15 85% = \$220.05		
	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance		
13020	(See para TN.1.1 of explanatory notes to this Category) <b>Fee:</b> \$263.00 <b>Benefit:</b> 75% = \$197.25 85% = \$223.55		
	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour)		
13025	(See para TN.1.1 of explanatory notes to this Category) <b>Fee:</b> \$117.55 <b>Benefit:</b> 75% = \$88.20 85% = \$99.95		
	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 a hour)		
13030	(See para TN.1.1 of explanatory notes to this Category) <b>Fee:</b> \$166.05 <b>Benefit:</b> 75% = \$124.55  85% = \$141.15		
T1. MIS	CELLANEOUS THERAPEUTIC DURES 2. DIALYSIS		
	Group T1. Miscellaneous Therapeutic Procedures		
	Subgroup 2. Dialysis		
	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day		
13100	(See para TN.1.2 of explanatory notes to this Category) <b>Fee:</b> \$138.85 <b>Benefit:</b> 75% = \$104.15 85% = \$118.05		
13103	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance		

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 2. DIALYSIS		
	time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day		
	(See para TN.1.2 of explanatory notes to this Category) <b>Fee:</b> \$72.35 <b>Benefit:</b> 75% = \$54.30 85% = \$61.50		
	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year		
13104	(See para TN.1.3, TN.1.23 of explanatory notes to this Category) <b>Fee:</b> \$150.30 <b>Benefit:</b> 85% = \$127.80		
	Haemodialysis for a patient with end-stage renal disease if:		
	(a) the service is provided by a registered nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner; and		
	(b) the service is supervised by the medical practitioner (either in person or remotely); and		
	(c) the patient's care is managed by a nephrologist; and		
	(d) the patient is treated or reviewed by the nephrologist every 3 to 6 months (either in person or remotely); and		
	(e) the patient is not an admitted patient of a hospital; and		
	(f) the service is provided in a Modified Monash 7 area		
13105	<b>Fee:</b> \$601.45 <b>Benefit:</b> 100% = \$601.45		
	DECLOTTING OF AN ARTERIOVENOUS SHUNT		
13106	<b>Fee:</b> \$123.30 <b>Benefit:</b> 75% = \$92.50 85% = \$104.85		
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)		
13109	<b>Fee:</b> \$231.40 <b>Benefit:</b> 75% = \$173.55 85% = \$196.70		
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS , removal of (including catheter cuffs) (Anaes.)		
13110	<b>Fee:</b> \$232.15 <b>Benefit:</b> 75% = \$174.15 85% = \$197.35		
T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES		
	Group T1. Miscellaneous Therapeutic Procedures		
	Subgroup 3. Assisted Reproductive Services		
EMSN 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		

T1. MISO PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	calendar year
	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$3,160.50 <b>Benefit:</b> 75% = \$2370.40 85% = \$3075.80 <b>Extended Medicare Safety Net Cap:</b> \$1,702.30
	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
<b>EMSN</b> 13201	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$2,956.30 <b>Benefit:</b> 75% = \$2217.25 85% = \$2871.60 <b>Extended Medicare Safety Net Cap:</b> \$2,471.05
	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
<b>EMSN</b> 13202	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$473.00 <b>Benefit:</b> 75% = \$354.75 85% = \$402.05 <b>Extended Medicare Safety Net Cap:</b> \$66.00
	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
<b>EMSN</b> 13203	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$494.55 <b>Benefit:</b> 75% = \$370.95 85% = \$420.40 <b>Extended Medicare Safety Net Cap:</b> \$109.90
	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
<b>EMSN</b> 13206	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$473.00 <b>Benefit:</b> 75% = \$354.75 85% = \$402.05 <b>Extended Medicare Safety Net Cap:</b> \$66.00
	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
<b>EMSN</b> 13209	(See para TN.1.4 of explanatory notes to this Category)  Fee: \$86.05  Benefit: 75% = \$64.55  Extended Medicare Safety Net Cap: \$11.05
EMSN 13210	Professional attendance on a patient by a specialist practising in his or her specialty if:

T1. MISO	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	(a) the attendance is by video conference; and
	(b) item 13209 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
	(See para TN.1.21 of explanatory notes to this Category)  Derived Fee: 50% of the fee for item 13209. Benefit: 85% of the derived fee  Extended Medicare Safety Net Cap: \$5.40
	Oocyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.)
<b>EMSN</b> 13212	(See para TN.1.4 of explanatory notes to this Category)  Fee: \$360.10 Benefit: 75% = \$270.10 85% = \$306.10  Extended Medicare Safety Net Cap: \$71.50
	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination-only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.)
<b>EMSN</b> 13215	(See para TN.1.4 of explanatory notes to this Category)  Fee: \$112.90  Benefit: 75% = \$84.70 85% = \$96.00  Extended Medicare Safety Net Cap: \$49.50
	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.)
<b>EMSN</b> 13218	(See para TN.1.4, TN.1.5 of explanatory notes to this Category)  Fee: \$806.25 Benefit: 75% = \$604.70 85% = \$721.55  Extended Medicare Safety Net Cap: \$713.90
	Preparation of semen for the purpose of artificial insemination-only if rendered in connection with a service to which item 13203 applies
<b>EMSN</b> 13221	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$51.60 <b>Benefit:</b> 75% = \$38.70 85% = \$43.90 <b>Extended Medicare Safety Net Cap:</b> \$22.05

	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICE			
	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies			
	(See para TN.1.5 of explanatory notes to this Category)			
EMSN	<b>Fee:</b> \$424.65 <b>Benefit:</b> 75% = \$318.50 85% = \$361.00			
13251	Extended Medicare Safety Net Cap: \$109.90			
	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage) - one of a maximum of two semen collection cycles per patient in a lifetime.			
	(See para TN.1.22 of explanatory notes to this Category)			
	<b>Fee:</b> \$421.65 <b>Benefit:</b> 75% = \$316.25 85% = \$358.45			
13260	Extended Medicare Safety Net Cap: \$274.10			
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required			
13290	<b>Fee:</b> \$207.50 <b>Benefit:</b> 75% = \$155.65 85% = \$176.40			
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital (Anaes.)			
13292				
T1. MIS	general anaesthetic, in a hospital (Anaes.)			
T1. MIS	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00  SCELLANEOUS THERAPEUTIC			
T1. MIS	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25  Benefit: 75% = \$311.45  85% = \$353.00  SCELLANEOUS THERAPEUTIC EDURES  4. PAEDIATRIC & NEONATA			
T1. MIS	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00  SCELLANEOUS THERAPEUTIC EDURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures			
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00  CCELLANEOUS THERAPEUTIC  DURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures  Subgroup 4. Paediatric & Neonatal  UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or			
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00  SCELLANEOUS THERAPEUTIC EDURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures  Subgroup 4. Paediatric & Neonatal  UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate			
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00  GCELLANEOUS THERAPEUTIC  EDURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures  Subgroup 4. Paediatric & Neonatal  UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate  Fee: \$57.85 Benefit: 75% = \$43.40 85% = \$49.20  UMBILICAL ARTERY CATHETERISATION with or without infusion			
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00  CCELLANEOUS THERAPEUTIC  EDURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures  Subgroup 4. Paediatric & Neonatal  UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate  Fee: \$57.85 Benefit: 75% = \$43.40 85% = \$49.20			
13300 13303	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25 Benefit: 75% = \$311.45 85% = \$353.00  CELLANEOUS THERAPEUTIC  EDURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures  Subgroup 4. Paediatric & Neonatal  UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate  Fee: \$57.85 Benefit: 75% = \$43.40 85% = \$49.20  UMBILICAL ARTERY CATHETERISATION with or without infusion  Fee: \$85.75 Benefit: 75% = \$64.35 85% = \$72.90  BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection			
13300 13303	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25  Benefit: 75% = \$311.45  85% = \$353.00  GCELLANEOUS THERAPEUTIC  EDURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures  Subgroup 4. Paediatric & Neonatal  UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate  Fee: \$57.85  Benefit: 75% = \$43.40  UMBILICAL ARTERY CATHETERISATION with or without infusion  Fee: \$85.75  Benefit: 75% = \$64.35  85% = \$72.90  BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor			
T1. MIS	general anaesthetic, in a hospital (Anaes.)  Fee: \$415.25  Benefit: 75% = \$311.45  85% = \$353.00  CELLANEOUS THERAPEUTIC  DURES  4. PAEDIATRIC & NEONATA  Group T1. Miscellaneous Therapeutic Procedures  Subgroup 4. Paediatric & Neonatal  UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate  Fee: \$57.85  Benefit: 75% = \$43.40  UMBILICAL ARTERY CATHETERISATION with or without infusion  Fee: \$85.75  Benefit: 75% = \$64.35  85% = \$72.90  BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor  Fee: \$339.45  Benefit: 75% = \$254.60  85% = \$288.55  BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already			

	CELLANEOUS T DURES	HERAPEUTIC 4. PAEDIATRIC & NEONATAL
	Fee: \$28.90	<b>Benefit:</b> 75% = \$21.70 85% = \$24.60
	CENTRAL VEI	N CATHETERISATION - by open exposure in a person under 12 years of age (Anaes.)
13318	(See para TN.1.6 or <b>Fee:</b> \$231.10	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$173.35 85% = \$196.45
	CENTRAL VEI	N CATHETERISATION in a neonate via peripheral vein (Anaes.)
13319	<b>Fee:</b> \$231.10	<b>Benefit:</b> 75% = \$173.35 85% = \$196.45
	CELLANEOUS T DURES	HERAPEUTIC 5. CARDIOVASCULAI
	Group T1. Misc	ellaneous Therapeutic Procedures
		Subgroup 5. Cardiovascular
		N OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the c surgery (Anaes.)
13400	Fee: \$98.35	<b>Benefit:</b> 75% = \$73.80 85% = \$83.60
	CELLANEOUS T	HERAPEUTIC 6. GASTROENTEROLOG
	Group T1. Misc	ellaneous Therapeutic Procedures
		Subgroup 6. Gastroenterology
	GASTRO-OESO	DPHAGEAL balloon intubation, for control of bleeding from gastric oesophageal varice
13506	<b>Fee:</b> \$187.45	<b>Benefit:</b> 75% = \$140.60 85% = \$159.35
	CELLANEOUS T	HERAPEUTIC 8. HAEMATOLOG
	Group T1. Misc	ellaneous Therapeutic Procedures
		Subgroup 8. Haematology
		OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the plantation (Anaes.)
13700	Fee: \$338.60	<b>Benefit:</b> 75% = \$253.95 85% = \$287.85
	TRANSFUSION	OF BLOOD, including collection from donor
13703	Fee: \$121.40	<b>Benefit:</b> 75% = \$91.05 85% = \$103.20
	TRANSFUSION	OF BLOOD or bone marrow already collected
13706	(See para TN.1.7 o <b>Fee:</b> \$84.70	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$63.55 85% = \$72.00
		OF BLOOD for autologous transfusion or when homologous blood is required for fusion in emergency situation
	İ	

	DURES		8. HAEMATOLOGY
	Fee: \$49.25	<b>Benefit:</b> 75% = \$36.95	85% = \$41.90
	utilising continuo viability studies, other parameters	ous or intermittent flow tec if performed; continuous n with continuous registered	ne removal of plasma or cellular (or both) elements of blood, hniques; including morphological tests for cell counts and nonitoring of vital signs, fluid balance, blood volume and nurse attendance under the supervision of a consultant th a service to which item 13755 applies -payable once per
13750	Fee: \$138.85	<b>Benefit:</b> 75% = \$104.15	5 85% = \$118.05
	intermittent flow continuous monit registered nurse a	techniques; including mor foring of vital signs, fluid b attendance under the super-	tion of blood products for transfusion, utilising continuous or phological tests for cell counts and viability studies; valance, blood volume and other parameters; with continuous vision of a consultant physician; not being a service 50 applies - payable once per day
13755	Fee: \$138.85	<b>Benefit:</b> 75% = \$104.15	5 85% = \$118.05
	THERAPEUTIC porphyria cutanea		nanagement of haemochromatosis, polycythemia vera or
13757	<b>Fee:</b> \$74.10	<b>Benefit:</b> 75% = \$55.60	85% = \$63.00
	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for:		
	. chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or		
	. Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or		
	. acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogeneic bone marrow transplant; or		
	. multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or		
	. small round cell sarcomas; or		
	. primitive neuroectodermal tumour; or		
	. germ cell tumours which have relapsed following, or are refractory to, chemotherapy;		
germ cell tumours which have had an incomplete response to first line therapy.		mplete response to first line therapy.	
	- performed under the supervision of a consultant physician - each day.		ultant physician - each day.
13760	Fee: \$774.80	<b>Benefit:</b> 75% = \$581.10	85% = \$690.10
	CELLANEOUS TI DURES	HERAPEUTIC	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
	Group T1. Misce	llaneous Therapeutic Pro	ocedures
	Subgro	oup 9. Procedures Associat	ed With Intensive Care And Cardiopulmonary Support
13815	CENTRAL VEIN	N CATHETERISATION b	y percutaneous or open exposure not being a service to

	CELLANEOUS THERAPEUTIC DURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
	which item 13318 applies (Anaes.)		
	(See para TN.1.6 of explanatory notes to this Ca <b>Fee:</b> \$86.60 <b>Benefit:</b> 75% = \$64.95	± •	
	RIGHT HEART BALLOON CATHETER, cardiac output measurement (Anaes.)	insertion of, including pulmonary wedge pressure and	
13818	(See para TN.1.10 of explanatory notes to this C <b>Fee:</b> \$115.50 <b>Benefit:</b> 75% = \$86.65	- · ·	
	INTRACRANIAL PRESSURE, monitoring bolt or similar, by a specialist or consultant	g of, by intraventricular or subdural catheter, subarachnoid physician - each day	
13830	<b>Fee:</b> \$76.55 <b>Benefit:</b> 75% = \$57.45	85% = \$65.10	
	ARTERIAL PUNCTURE and collection of	blood for diagnostic purposes	
13839	<b>Fee:</b> \$23.40 <b>Benefit:</b> 75% = \$17.55	85% = \$19.90	
	INTRAARTERIAL CANNULATION for the purpose of taking multiple arterial blood samples for blood gas analysis		
13842	(See para TN.1.10 of explanatory notes to this C <b>Fee:</b> \$70.40 <b>Benefit:</b> 75% = \$52.80		
	COUNTERPULSATION BY INTRAAOR initial and subsequent consultations and mo	TIC BALLOON management on the first day including onitoring of parameters (Anaes.)	
13847	(See para TN.1.10 of explanatory notes to this C <b>Fee:</b> \$158.60 <b>Benefit:</b> 75% = \$118.95		
	COUNTERPULSATION BY INTRAAOR first, including associated consultations and	TIC BALLOON management on each day subsequent to the monitoring of parameters	
13848	(See para TN.1.10 of explanatory notes to this Category) <b>Fee:</b> \$133.15 <b>Benefit:</b> 75% = \$99.90  85% = \$113.20		
	CIRCULATORY SUPPORT DEVICE, management of, on first day		
13851	<b>Fee:</b> \$501.55 <b>Benefit:</b> 75% = \$376.20	0 85% = \$426.35	
	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first		
13854	<b>Fee:</b> \$116.70 <b>Benefit:</b> 75% = \$87.55	85% = \$99.20	
	AIRWAY ACCESS, ESTABLISHMENT OF AND INITIATION OF MECHANICAL VENTILATIO (other than in the context of an anaesthetic for surgery), outside an Intensive Care Unit, for the purpose of subsequent ventilatory support in an Intensive Care Unit		
13857	(See para TN.1.10 of explanatory notes to this C <b>Fee:</b> \$148.75 <b>Benefit:</b> 75% = \$111.60		
	CELLANEOUS THERAPEUTIC DURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
	Group T1. Miscellaneous Therapeutic Pro	ocedures	
	Subgroup 10. Management An	d Procedures Undertaken In An Intensive Care Unit	

	SCELLANEOUS THERAPEUTIC EDURES UND	10. MANAGEMENT AND PROCEDURES ERTAKEN IN AN INTENSIVE CARE UNIT	
	(Note: See para T1.8 of Expla	natory Notes to this	
	Category for definition of an I	Intensive Care Unit)	
	MANAGEMENT of a patient in an Intensive Care Unit be immediately available and exclusively rostered for intensi attendances, electrocardiographic monitoring, arterial sammanagement on the first day (H)  (See para TN.1.9, TN.1.11, TN.1.10 of explanatory notes to this	ve care - including initial and subsequent upling and bladder catheterisation -	
13870	Fee: \$367.90 Benefit: 75% = \$275.95	Category)	
	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - including all attendances, electrocardiographic monitoring, arterial sampling and bladder catheterisation - management on each day subsequent to the first day (H)		
13873	(See para TN.1.9, TN.1.11 of explanatory notes to this Category <b>Fee:</b> \$272.90 <b>Benefit:</b> 75% = \$204.70	)	
	CENTRAL VENOUS PRESSURE, pulmonary arterial printracavity pressure, continuous monitoring by indwelling by a specialist or consultant physician who is immediately intensive care - once only for each type of pressure on any pressures) (H)	catheter in an intensive care unit and managed vavailable and exclusively rostered for	
13876	(See para TN.1.9, TN.1.11, TN.1.10 of explanatory notes to this <b>Fee:</b> \$78.15 <b>Benefit:</b> 75% = \$58.65	Category)	
	AIRWAY ACCESS, ESTABLISHMENT OF AND INIT VENTILATION, in an Intensive Care Unit, not in associa specialist or consultant physician for the purpose of subse	tion with any anaesthetic service, by a	
13881	(See para TN.1.9, TN.1.11 of explanatory notes to this Category <b>Fee:</b> \$148.75 <b>Benefit:</b> 75% = \$111.60	)	
	VENTILATORY SUPPORT in an Intensive Care Unit, m invasive means where the only alternative to non-invasive ventilatory support, by a specialist or consultant physician rostered for intensive care, each day (H)	ventilatory support would be invasive	
13882	(See para TN.1.9, TN.1.11 of explanatory notes to this Category <b>Fee:</b> \$117.10 <b>Benefit:</b> 75% = \$87.85	)	
	CONTINUOUS ARTERIO VENOUS OR VENO VENO care unit, management by a specialist or consultant physic exclusively rostered for intensive care - on the first day (F	cian who is immediately available and	
13885	(See para TN.1.9, TN.1.11 of explanatory notes to this Category <b>Fee:</b> \$156.10 <b>Benefit:</b> 75% = \$117.10	)	
13888	CONTINUOUS ARTERIO VENOUS OR VENO VENO care unit, management by a specialist or consultant physic		

	CELLANEOUS THERAPEUTIC DURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
	exclusively rostered for intensive care - o	on each day subsequent to the first day (H)	
	(See para TN.1.9, TN.1.11 of explanatory note <b>Fee:</b> \$78.15 <b>Benefit:</b> 75% = \$58.6		
	CELLANEOUS THERAPEUTIC DURES	11. CHEMOTHERAPEUTIC PROCEDURES	
	Group T1. Miscellaneous Therapeutic F	Procedures	
	Subgroup	11. Chemotherapeutic Procedures	
	into a vein, or a butterfly needle, or the si than 1 hours duration - payable once only	inistration of, either by intravenous push technique (directly de-arm of an infusion) or by intravenous infusion of not more on the same day, not being a service associated with r for the administration of drugs used immediately prior to, or r therapy alone	
13915	(See para TN.1.12 of explanatory notes to this <b>Fee:</b> \$66.10 <b>Benefit:</b> 75% = \$49.6		
	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		
13918	<b>Fee:</b> \$99.50 <b>Benefit:</b> 75% = \$74.6	65 85% = \$84.60	
	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment		
13921	<b>Fee:</b> \$112.55 <b>Benefit:</b> 75% = \$84.4	45 85% = \$95.70	
	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode		
13924	<b>Fee:</b> \$66.30 <b>Benefit:</b> 75% = \$49.7	75 85% = \$56.40	
	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		
13927	<b>Fee:</b> \$85.75 <b>Benefit:</b> 75% = \$64.3	35 85% = \$72.90	
	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day		
13930	<b>Fee:</b> \$119.70 <b>Benefit:</b> 75% = \$89.8	80 85% = \$101.75	
	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment		
13933	<b>Fee:</b> \$132.80 <b>Benefit:</b> 75% = \$99.6	60 85% = \$112.90	
		inistration of, by intra-arterial infusion of more than 6 hours first in the same continuous treatment episode	
13936	<b>Fee:</b> \$86.50 <b>Benefit:</b> 75% = \$64.9	90 85% = \$73.55	
13939		loading of, with a cytotoxic agent or agents, not being a service 3915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or	

	CELLANEOUS THERAPEUTIC
PROCE	DURES 11. CHEMOTHERAPEUTIC PROCEDURES  13945 applies
	(See para TN.1.13 of explanatory notes to this Category) <b>Fee:</b> \$99.50 <b>Benefit:</b> 75% = \$74.65  85% = \$84.60
	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933, 13936 or 13945 applies
13942	(See para TN.1.13 of explanatory notes to this Category) <b>Fee:</b> \$66.30 <b>Benefit:</b> 75% = \$49.75  85% = \$56.40
	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of
13945	<b>Fee:</b> \$53.35 <b>Benefit:</b> 75% = \$40.05 85% = \$45.35
	CYTOTOXIC AGENT, instillation of, into a body cavity
13948	<b>Fee:</b> \$66.30 <b>Benefit:</b> 75% = \$49.75 85% = \$56.40
	CELLANEOUS THERAPEUTIC DURES 12. DERMATOLOGY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 12. Dermatology
	UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology
	Applicable not more than 150 times in a 12 month period
14050	(See para TN.1.14 of explanatory notes to this Category) <b>Fee:</b> \$53.60 <b>Benefit:</b> 75% = \$40.20 85% = \$45.60
	Laser photocoagulation using laser radiation in the treatment of vascular abnormalities of the head or neck, including any associated consultation, if:
	(a) the abnormality is visible from 3 metres; and
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes;
	to a maximum of 4 sessions (including any sessions to which this item or any of items 14106 to 14118 apply) in any 12 month period (Anaes.)
14100	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> \$154.95
14106	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment less than 150 cm <sup>2</sup> (Anaes.)

	CELLANEOUS THERAPEUTIC DURES 12. DERMATOLOGY		
	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> \$162.70 <b>Benefit:</b> 75% = \$122.05 85% = \$138.30		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm <sup>2</sup> to 300 cm <sup>2</sup> (Anaes.)		
14115	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> \$260.60 <b>Benefit:</b> 75% = \$195.45  85% = \$221.55		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm <sup>2</sup> (Anaes.)		
14118	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> \$330.95 <b>Benefit:</b> 75% = \$248.25 85% = \$281.35		
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, if:		
	(a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 to 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and		
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)		
14124	(See para TN.1.15 of explanatory notes to this Category) <b>Fee:</b> \$154.95 <b>Benefit:</b> 75% = \$116.25  85% = \$131.75		
	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES		
	Group T1. Miscellaneous Therapeutic Procedures		
	Subgroup 13. Other Therapeutic Procedures		
	GASTRIC LAVAGE in the treatment of ingested poison		
14200	<b>Fee:</b> \$60.75 <b>Benefit:</b> 75% = \$45.60 85% = \$51.65		
	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient		
14201	(See para TN.1.16 of explanatory notes to this Category)  Fee: \$240.65  Benefit: 75% = \$180.50  Extended Medicare Safety Net Cap: \$36.10		
	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953		
14202			

	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES	
	(See para TN.1.16 of explanatory notes to this Category)  Fee: \$121.80  Benefit: 75% = \$91.35 85% = \$103.55  Extended Medicare Safety Net Cap: \$18.30	
	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)	
14203	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) <b>Fee:</b> \$51.95 <b>Benefit:</b> 75% = \$39.00 85% = \$44.20	
	HORMONE OR LIVING TISSUE IMPLANTATION by cannula	
14206	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) <b>Fee:</b> \$36.15 <b>Benefit:</b> 75% = \$27.15  85% = \$30.75	
	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent	
14209	<b>Fee:</b> \$90.10 <b>Benefit:</b> 75% = \$67.60 85% = \$76.60	
	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)	
14212	<b>Fee:</b> \$188.25 <b>Benefit:</b> 75% = \$141.20 85% = \$160.05	
	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain	
14218	<b>Fee:</b> \$99.50 <b>Benefit:</b> 75% = \$74.65 85% = \$84.60	
	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of not being a service associated with a service to which item 13945 applies	
14221	<b>Fee:</b> \$53.35 <b>Benefit:</b> 75% = \$40.05 85% = \$45.35	
	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	
14224	<b>Fee:</b> \$71.50 <b>Benefit:</b> 75% = \$53.65 85% = \$60.80	
	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity	
14227	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$99.50 <b>Benefit:</b> 75% = \$74.65  85% = \$84.60	
	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, for connection to a subcutaneous implanted infusion pump, for the management of severe chronic spasticity with baclofen (Anaes.) (Assist.)	
14230	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$302.80 <b>Benefit:</b> 75% = \$227.10	
	INFUSION PUMP, subcutaneous implantation or replacement of, and connection to intrathecal or epidural catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.)	
14233	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$367.70 <b>Benefit:</b> 75% = \$275.80	
14236	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL CATHETER	

T1. MIS	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDURES	
	insertion, and connection of pump to catheter and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.) (Assist.)	
	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$670.50 <b>Benefit:</b> 75% = \$502.90	
	Removal of subcutaneously IMPLANTED INFUSION PUMP, OR removal or repositioning of intrathecal or epidural SPINAL CATHETER, for the management of severe chronic spasticity (Anaes.)	
14239	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$161.95 <b>Benefit:</b> 75% = \$121.50	
	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the management of severe chronic spasticity (Anaes.)	
14242	(See para TN.1.18 of explanatory notes to this Category) <b>Fee:</b> \$481.25 <b>Benefit:</b> 75% = \$360.95	
	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme	
14245	(See para TN.1.19 of explanatory notes to this Category) <b>Fee:</b> \$99.50 <b>Benefit:</b> 75% = \$74.65 85% = \$84.60	
T2. RAI	DIATION ONCOLOGY 1. SUPERFICIAL	
	Group T2. Radiation Oncology	
	Subgroup 1. Superficial	
	(Benefits for administration of general anaesthetic for radiotherapy are payable under Group T10)	
	RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given	
	- 1 field	
15000	<b>Fee:</b> \$43.25 <b>Benefit:</b> 75% = \$32.45 85% = \$36.80	
	Radiotherapy, superficial (including treatment with x-rays, 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 - 2 or more fields up to a maximum of 5 additional fields	
Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$17.35		
	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied	
	- 1 field	
15006	<b>Fee:</b> \$95.85 <b>Benefit:</b> 75% = \$71.90 85% = \$81.50	
15009	Radiotherapy, superficial attendance at which a single dose technique is applied - 2 or more fields up to	

T2. RAI	DIATION ONCOLOGY 1. SUPERFICI
	a maximum of 5 additional fields
	Desired Front Floor Control of the C
	<b>Derived Fee:</b> The fee for item 15006 plus for each field in excess of 1, an amount of \$18.85  RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye
15012	
15012 <b>T2. RAI</b>	Fee: \$54.30   Benefit: 75% = \$40.75   85% = \$46.20     DIATION ONCOLOGY   2. ORTHOVOLTAGE
	Group T2. Radiation Oncology
	Subgroup 2. Orthovoltage
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week
	- 1 field
15100	(See para TN.2.1 of explanatory notes to this Category) <b>Fee:</b> \$48.45 <b>Benefit:</b> 75% = \$36.35  85% = \$41.20
	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or mot treatments per week - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being fields)
15103	(See para TN.2.1 of explanatory notes to this Category)  Derived Fee: The fee for item 15100 plus for each field in excess of 1, an amount of \$19.10
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment i given at 2 treatments per week or less frequently
	- 1 field
15106	<b>Fee:</b> \$57.20 <b>Benefit:</b> 75% = \$42.90 85% = \$48.65
	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)
15109	<b>Derived Fee:</b> The fee for item 15106 plus for each field in excess of 1, an amount of \$23.05
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field
15112	<b>Fee:</b> \$122.15 <b>Benefit:</b> 75% = \$91.65 85% = \$103.85
	Radiotherapy, deep or orthovoltage attendance at which a single dose technique is applied - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)
15115	

T2. RAD	DIATION ONCOLOGY 2. ORTHOVOLTAGE	
	<b>Derived Fee:</b> The fee for item 15112 plus for each field in excess of 1, an amount of \$48.05	
T2. RAD	DIATION ONCOLOGY 3. MEGAVOLTAGE	
	Group T2. Radiation Oncology	
	Subgroup 3. Megavoltage	
	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given	
	- 1 field	
15211	<b>Fee:</b> \$55.60 <b>Benefit:</b> 75% = \$41.70 85% = \$47.30	
	Radiation oncology treatment, using cobalt unit or caesium teletherapy unit - each attendance at which treatment is given 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields)	
15214	<b>Derived Fee:</b> The fee for item 15211 plus for each field in excess of 1, an amount of \$32.40	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered primary site (lung)	
15215	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	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)	
15218	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	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)	
15221	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221	
15224	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	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 secondary site	
15227	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
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 si (lung)	

T2. RAI	DIATION ONCOLOGY	3. MEGAVOLTAGE
	<b>Derived Fee:</b> The fee for item 15215 plus for each field in excess of 1, an amo	ount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a single photon energy without electron facilities - each attendance at which treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment (prostate)	- 2 or more fields up to a
15233	<b>Derived Fee:</b> The fee for item 15218 plus for each field in excess of 1, an amo	ount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a single photon energy without electron facilities - each attendance at which treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment (breast)	- 2 or more fields up to a
15236	<b>Derived Fee:</b> The fee for item 15221 plus for each field in excess of 1, an amo	ount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a single photon energy without electron facilities - each attendance at which treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment diseases and conditions not covered by items 15230, 15233 or 15236	- 2 or more fields up to a ment delivered to primary site
15239	Derived Fee: The fee for item 15224 plus for each field in excess of 1, an amo	ount of \$38.55
	RADIATION ONCOLOGY TREATMENT, using a single photon energy without electron facilities - each attendance at which treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational therapy being 3 fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - maximum of 5 additional fields (rotational fields) - treatment is given - m	- 2 or more fields up to a
15242	Derived Fee: The fee for item 15227 plus for each field in excess of 1, an amount of \$38.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung)	
15245	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate)	
15248	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast)	
15251	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251	
15254	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy minimum higher energy of at least 10MV photons, with electron facilitie treatment is given - 1 field - treatment delivered to secondary site	
15257	<b>Fee:</b> \$60.60 <b>Benefit:</b> 75% = \$45.45 85% = \$51.55	
	RADIATION ORADIATION ONCOLOGY treatment, using a dual pho	

T2. RAD	DIATION ONCOLOGY 3. MEGAVOLTAG	
	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)	
	<b>Derived Fee:</b> The fee for item 15245 plus for each field in excess of 1, an amount of \$38.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate)	
15263	<b>Derived Fee:</b> The fee for item 15248 plus for each field in excess of 1, an amount of \$38.55	
	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)	
15266	<b>Derived Fee:</b> The fee for item 15251 plus for each field in excess of 1, an amount of \$38.55	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266	
15269	<b>Derived Fee:</b> The fee for item 15254 plus for each field in excess of 1, an amount of \$38.55	
	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	
15272	<b>Derived Fee:</b> The fee for item 15257 plus for each field in excess of 1, an amount of \$38.55	
	RADIATION ONCOLOGY TREATMENT with IGRT imaging facilities undertaken:	
	(a) to implement an IMRT dosimetry plan prepared in accordance with item 15565; and	
	(b) utilising an intensity modulated treatment delivery mode (delivered by a fixed or dynamic gantry linear accelerator or by a helical non C-arm based linear accelerator), once only at each attendance at which treatment is given.	
15275	<b>Fee:</b> \$185.85 <b>Benefit:</b> 75% = \$139.40 85% = \$158.00	
T2. RAD	DIATION ONCOLOGY 4. BRACHYTHERAP	
	Group T2. Radiation Oncology	
	Subgroup 4. Brachytherapy	
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)	
15303	<b>Fee:</b> \$362.70 <b>Benefit:</b> 75% = \$272.05 85% = \$308.30	
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)	

T2. RAI	NATION ONCOLOGY		4. BRACHYTHERAPY	
	Fee: \$362.70	<b>Benefit:</b> 75% = \$272.05	85% = \$308.30	
			sing radioactive sealed sources having a half-life of less or tantalum using manual afterloading techniques (Anaes.)	
15307	Fee: \$687.65	<b>Benefit:</b> 75% = \$515.75	85% = \$602.95	
			sing radioactive sealed sources having a half-life of less or tantalum using automatic afterloading techniques	
15308	Fee: \$687.65	<b>Benefit:</b> 75% = \$515.75	85% = \$602.95	
		AL TREATMENT ALONE ing manual afterloading tech	using radioactive sealed sources having a half-life greater nniques (Anaes.)	
15311	Fee: \$338.55	<b>Benefit:</b> 75% = \$253.95	85% = \$287.80	
		AL TREATMENT ALONE ing automatic afterloading to	using radioactive sealed sources having a half-life greater echniques (Anaes.)	
15312	<b>Fee:</b> \$336.10	<b>Benefit:</b> 75% = \$252.10	85% = \$285.70	
			using radioactive sealed sources having a half-life of less or tantalum using manual afterloading techniques (Anaes.)	
15315	<b>Fee:</b> \$664.70	<b>Benefit:</b> 75% = \$498.55	85% = \$580.00	
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)			
15316	<b>Fee:</b> \$664.70	<b>Benefit:</b> 75% = \$498.55	85% = \$580.00	
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)			
15319	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	85% = \$350.70	
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.)			
15320	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	85% = \$350.70	
	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)			
15323	Fee: \$733.55	<b>Benefit:</b> 75% = \$550.20	85% = \$648.85	
	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.)			
15324	<b>Fee:</b> \$733.55	<b>Benefit:</b> 75% = \$550.20	85% = \$648.85	
	including iodine	gold, iridium or tantalum) t	ACTIVE SOURCE (having a half-life of less than 115 days o a region, under general anaesthesia, or epidural or spinal exposure and using manual afterloading techniques (Anaes.)	
15327	Fee: \$798.00	<b>Benefit:</b> 75% = \$598.50	85% = \$713.30	
15328	IMPLANTATIO	N OF A SEALED RADIO	ACTIVE SOURCE (having a half-life of less than 115 days	

(intra (Anac		
IMPL include subcut expose 15331 Fee: 3 IMPL include plane 15335 Fee: 3 IMPL include plane 15336 Fee: 3 IMPL include plane 153	NTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days ng iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, meous sites), where the volume treated involves multiple planes but does not require surgical	
include subcut exposes 15331  Fee: 3  IMPL include subcut exposes 15332  Fee: 3  IMPL include plane 15335  Fee: 3  IMPL include plane 15336  PROS ultrass tumor score the tingurology (See properties of the plane 15338  REM spinar 15339  Fee: 3  CONS havin 15342  Fee: 3	ng iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, ineous sites), where the volume treated involves multiple planes but does not require surgical	
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include subcut expose subcut e	57.75 <b>Benefit:</b> 75% = \$568.35 85% = \$673.05	
IMPL include plane  15335 Fee: 3  IMPL include plane  15336 Fee: 3  PROS ultras tumor score the tire urology (See properties of the plane)  15338 Fee: 3  REM spinar  15339 Fee: 3  CON havin  15342 Fee: 3	NTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days ng iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, meous sites), where the volume treated involves multiple planes but does not require surgical re and using automatic afterloading techniques (Anaes.)	
include plane  15335 Fee: 3  IMPI include plane  15336 Fee: 3  PROS ultras tumor score the tin urology  (See p. 15338 Fee: 3  REM spina.  15339 Fee: 3  CON: havin  15342 Fee: 3	57.75 <b>Benefit:</b> 75% = \$568.35 85% = \$673.05	
IMPL include plane  15336 Fee: 3  PROS ultras tumor score the tire urology (See p. 15338 Fee: 3  REM spinar CON havin 15342 Fee: 3	NTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days ng iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single ut does not require surgical exposure and using manual afterloading techniques (Anaes.)	
include plane  15336  Fee: 3  PROSultras tumor score the tire urology (See program Fee: 3  REM spinal  15339  Fee: 3  CON havin  15342  Fee: 3	87.65 <b>Benefit:</b> 75% = \$515.75 85% = \$602.95	
PROSultras tumor score the tin urolo (See p Fee: 3 REM spinal 15339 Fee: 3 CON havin 15342 Fee: 3	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 da 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.)	
ultras tumor score the tire urology (See properties of the seed of	87.65 <b>Benefit:</b> 75% = \$515.75 85% = \$602.95	
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.	
REM spina  15339 Fee: 3  CON havin  15342 Fee: 3	a TN.2.2 of explanatory notes to this Category)	
CON havin	50.55 <b>Benefit:</b> 75% = \$712.95 85% = \$865.85  VAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or herve block (Anaes.)	
havin 15342 <b>Fee:</b> 3	7.40 <b>Benefit:</b> 75% = \$58.05 85% = \$65.80	
	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	
	93.35 <b>Benefit:</b> 75% = \$145.05 85% = \$164.35	
havin	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	
15345 <b>Fee:</b> 3	15.90 <b>Benefit:</b> 75% = \$386.95 85% = \$438.55	
	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance	

T2. RA	DIATION ONCOL	.OGY	4. BRACHYTHERAPY
	<b>Fee:</b> \$59.35	<b>Benefit:</b> 75% = \$44.55	85% = \$50.45
			NITIAL APPLICATION OF RADIOACTIVE MOULD not
	exceeding 5 cm. diameter to an external surface		
15351	Fee: \$118.45	<b>Benefit:</b> 75% = \$88.85	85% = \$100.70
		CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface	
15354	Fee: \$143.75	<b>Benefit:</b> 75% = \$107.85	85% = \$122.20
	radioactive mou	ald constructed for application	DIOACTIVE MOULD, attendance upon a patient to apply a n to an external surface of the patient other than an ply the mould each attendance"
15357	Fee: \$40.70	<b>Benefit:</b> 75% = \$30.55	85% = \$34.60
T2. RA	DIATION ONCOL	.OGY	5. COMPUTERISED PLANNING
	Group T2. Radi	iation Oncology	
		Subgroup	5. Computerised Planning
		RADIO	THERAPY PLANNING
15500	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or single area for treatment by a single field or parallel opposed fields (not being a service associat service to which item 15509 applies)  (See para TN.2.3 of explanatory notes to this Category)  Fee: \$246.55  Benefit: 75% = \$184.95  85% = \$209.60		parallel opposed fields (not being a service associated with a egory)
	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT of single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies)		e are required for treatment by multiple fields, or of 2 areas
(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$316.55 <b>Benefit:</b> 75% = \$237.45  85% = \$269.10			
	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine or CT 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)		
15506	(See para TN.2.3 <b>Fee:</b> \$472.75	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$354.60	
	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment field or parallel opposed fields (not being a service associated with a service to which item applies)		
	(See para TN.2.3 <b>Fee:</b> \$213.65	of explanatory notes to this Cate	one)
15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in n 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associate service to which item 15503 applies)		• •
15509	RADIATION F 1 plane are requ	aired for treatment by multiple	85% = \$181.65 gnostic xray unit of a single area, where views in more than

T2. RAI	DIATION ONCOLOGY	5. COMPUTERISED PLANNING
	<b>Fee:</b> \$275.45 <b>Benefit:</b> 75% = \$206.60 85% = \$234.15	
	RADIATION SOURCE LOCALISATION using a simulator or x where views in more than 1 plane are required, for brachytherapy implantation of localised prostate cancer, in association with item	treatment planning for I125 seed
15513	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$311.45 <b>Benefit:</b> 75% = \$233.60 85% = \$264.75	
	RADIATION FIELD SETTING using a diagnostic xray unit of 3 body irradiation, or of mantle therapy or inverted Y fields, or of in blocks, or of offaxis fields or several joined fields (not being a seritem 15506 applies)	rregularly shaped fields using multiple
15515	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$398.80 <b>Benefit:</b> 75% = \$299.10 85% = \$339.00	
	RADIATION DOSIMETRY by a CT interfacing planning compuradiotherapy by a single field or parallel opposed fields to 1 areas	
15518	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$78.25 <b>Benefit:</b> 75% = \$58.70  85% = \$66.55	
	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 area or where wedges are used	
15521	(See para TN.2.3 of explanatory notes to this Category)  Fee: \$345.35  Benefit: 75% = \$259.05  85% = \$293.55	
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields	
15524	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$647.55 <b>Benefit:</b> 75% = \$485.70  85% = \$562.85	
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks	
15527	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$80.20 <b>Benefit:</b> 75% = \$60.15 85% = \$68.20	
	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 area or where wedges are used	
15530	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$357.80 <b>Benefit:</b> 75% = \$268.35 85% = \$304.15	
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletheral 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	
15533	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$678.40 <b>Benefit:</b> 75% = \$508.80 85% = \$593.70	
	BRACHYTHERAPY PLANNING, computerised radiation dosin	netry
15536	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$271.15 <b>Benefit:</b> 75% = \$203.40 85% = \$230.50	

T2. RAD	NATION ONCOLOGY	5. COMPUTERISED PLANNING
	BRACHYTHERAPY PLANNING, computerised radiation dosimet localised prostate cancer, in association with item 15338	ry for I125 seed implantation of
15539	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$637.35 <b>Benefit:</b> 75% = \$478.05  85% = \$552.65	
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RA contrast medium, where:	DIOTHERAPY without intravenous
	(a) treatment set up and technique specifications are in preparation radiotherapy dose planning; and	s for three dimensional conformal
	(b) patient set up and immobilisation techniques are suitable for reacquisition and three dimensional conformal radiotherapy treatments	
	(c) a high-quality CT-image volume dataset must be acquired for t planned and treated; and	the relevant region of interest to be
	(d) the image set must be suitable for the generation of quality digimages	itally reconstructed radiographic
15550	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$669.15 <b>Benefit:</b> 75% = \$501.90 85% = \$584.45	
	SIMULATION FOR THREE DIMENSIONAL CONFORMAL RA intravenous contrast medium, where:	DIOTHERAPY pre and post
	(a) treatment set up and technique specifications are in preparation radiotherapy dose planning; and	as for three dimensional conformal
	(b) patient set up and immobilisation techniques are suitable for reacquisition and three dimensional conformal radiotherapy treatments	
	(c) a high-quality CT-image volume dataset must be acquired for t planned and treated; and	he relevant region of interest to be
	(d) the image set must be suitable for the generation of quality digimages	itally reconstructed radiographic
15553	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$721.90 <b>Benefit:</b> 75% = \$541.45 85% = \$637.20	
	SIMULATION FOR INTENSITY-MODULATED RADIATION T intravenous contrast medium, if:	HERAPY (IMRT), with or without
	1. treatment set-up and technique specifications are in preparations radiotherapy dose planning; and	s for three-dimensional conformal
	2. patient set-up and immobilisation techniques are suitable for rel acquisition and three-dimensional conformal radiotherapy; and	iable CT-image volume data
	3. a high-quality CT-image volume dataset is acquired for the releand treated; and	vant region of interest to be planned
	4. the image set is suitable for the generation of quality digitally-re	econstructed radiographic images.
15555	(See para TN.2.3 of explanatory notes to this Category) <b>Fee:</b> \$721.90 <b>Benefit:</b> 75% = \$541.45 85% = \$637.20	

# T2. RADIATION ONCOLOGY 5. COMPUTERISED PLANNING 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 dose volume histograms must be generated, approved and recorded with the plan; and 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 TN.2.3 of explanatory notes to this Category) 15556 Fee: \$675.05 **Benefit:** 75% = \$506.30 85% = \$590.35 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 TN.2.3 of explanatory notes to this Category) 15559 Fee: \$880.40 **Benefit:** 75% = \$660.30 85% = \$795.70 DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where: 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

dosimetry for a two phase three dimensional conformal treatment plan using CT image volume

15562

### **T2. RADIATION ONCOLOGY**

### 5. COMPUTERISED PLANNING

datasets with at least one gross tumour volume, and

- (i) two planning target volumes; or
- (ii) two organ at risk dose goals or constraints defined in the prescription.

or

(c) dosimetry for a one phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, one planning target volume and three organ at risk dose goals or constraints defined in the prescription;

or

(d) image fusion with a secondary image (CT, MRI or PET) volume dataset used to define target and organ at risk volumes in conjunction with and as specified in dosimetry for three dimensional conformal radiotherapy of level 2 complexity.

All gross tumour targets, clinical targets, planning targets and organs at risk as defined in the prescription must be rendered as volumes. The organ at risk must be nominated as planning dose goals or constraints and the prescription must specify the organs at risk as dose goals or constraints. Dose volume histograms must be generated, approved and recorded with the plan. A CT image volume dataset must be used for the relevant region to be planned and treated. The CT images must be suitable for the generation of quality digitally reconstructed radiographic images

(See para TN.2.3 of explanatory notes to this Category)

**Fee:** \$1,138.70 **Benefit:** 75% = \$854.05 85% = \$1054.00

Preparation of an IMRT DOSIMETRY PLAN, which uses one or more CT image volume datasets, if:

- (a) in preparing the IMRT dosimetry plan:
  - (i) the differential between target dose and normal tissue dose is maximised, based on a review and assessment by a radiation oncologist; and
  - (ii) all gross tumour targets, clinical targets, planning targets and organs at risk are rendered as volumes as defined in the prescription; and
  - (iii) organs at risk are nominated as planning dose goals or constraints and the prescription specifies the organs at risk as dose goals or constraints; and
  - (iv) dose calculations and dose volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded in the plan; and
  - (v) a CT image volume dataset is used for the relevant region to be planned and treated; and
  - (vi) the CT images are suitable for the generation of quality digitally reconstructed radiographic images; and
- (b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include:
  - (i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and

15565

T2. RAD	DIATION ONCOLOGY	5. COMPUTERISED PLANNING	
	gantryposition (static or dynamic); and		
	(ii) ensuring that the plan is deliverable completed on a linear accelerator; and	e, data transfer is acceptable and validation checks are	
	(iii) validating the accuracy of the deri	ved IMRT dosimetry plan; and	
	(c) the final IMRT dosimetry plan is appr	roved by the radiation oncologist prior to delivery.	
	(See para TN.2.3 of explanatory notes to this Ca <b>Fee:</b> \$3,366.85 <b>Benefit:</b> 75% = \$2525.		
T2. RAD	DIATION ONCOLOGY	6. STEREOTACTIC RADIOSURGER	
	Group T2. Radiation Oncology		
	Subgrou	p 6. Stereotactic Radiosurgery	
	STEREOTACTIC RADIOSURGERY, inc simulation, dosimetry and treatment	luding all radiation oncology consultations, planning,	
15600	<b>Fee:</b> \$1,729.55 <b>Benefit:</b> 75% = \$1297.	20 85% = \$1644.85	
T2. RAD	DIATION ONCOLOGY	7. RADIATION ONCOLOGY TREATMEN VERIFICATION	
	Group T2. Radiation Oncology		
	Subgroup 7. Radiation Oncology Treatment Verification		
	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item or 15710 - each attendance at which treatment is verified (ie maximum one per attendance).		
15700	(See para TN.2.4 of explanatory notes to this Ca <b>Fee:</b> \$46.70 <b>Benefit:</b> 75% = \$35.05	- ·	
	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition we prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - attendance at which treatment involving three or more fields is verified (ie maximum one per attendance).		
15705	(See para TN.2.4 of explanatory notes to this Ca <b>Fee:</b> \$77.85 <b>Benefit:</b> 75% = \$58.40	• •	
	and reviewed by a radiation oncologist and	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribe and reviewed by a radiation oncologist and not associated with item 15700 or 15705 - each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance).	
	(see para T2.5 of explanatory notes to this	Category)	
15710	(See para TN.2.4 of explanatory notes to this Ca <b>Fee:</b> \$77.85 <b>Benefit:</b> 75% = \$58.40		
15715	Fee: \$77.85 Benefit: 75% = \$58.40 85% = \$66.20  RADIATION ONCOLOGY TREATMENT VERIFICATION of planar or volumetric IGRT for IMI involving the use of at least 2 planar image views or projections or 1 volumetric image set to facilita 3-dimensional adjustment to radiation treatment field positioning, if:		

# 7. RADIATION ONCOLOGY TREATMENT VERIFICATION (a) the treatment technique is classified as IMRT; and (b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or reduced to minimise treatment related exposure of healthy or normal tissues; and

- (c) the decisions made using acquired images are based on action algorithms and are given effect immediately prior to or during treatment delivery by qualified and trained staff considering complex competing factors and using software driven modelling programs; and
- (d) the radiation treatment field positioning requires accuracy levels of less than 5mm (curative cases) or up to 10mm (palliative cases) to ensure accurate dose delivery to the target; and
- (e) the image decisions and actions are documented in the patient's record; and
- (f) the radiation oncologist is responsible for supervising the process, including specifying the type and frequency of imaging, tolerance and action levels to be incorporated in the process, reviewing the trend analysis and any reports and relevant images during the treatment course and specifying action protocols as required; and
- (g) when treatment adjustments are inadequate to satisfy treatment protocol requirements, replanning is required; and
- (h) the imaging infrastructure (hardware and software) is linked to the treatment unit and networked to an image database, enabling both on line and off line reviews.

(See para TN.2.4 of explanatory notes to this Category)

**Fee:** \$77.85 **Benefit:** 75% = \$58.40 85% = \$66.20

T2. RAI	8. BRACHYTHERAPY PLANNING AND VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 8. Brachytherapy Planning And Verification
	BRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each attendance.
15800	(See para TN.2.4 of explanatory notes to this Category) <b>Fee:</b> \$97.85 <b>Benefit:</b> 75% = \$73.40 85% = \$83.20
	RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies.
15850	<b>Fee:</b> \$202.70 <b>Benefit:</b> 75% = \$152.05 85% = \$172.30
T2. RAI	10. TARGETED INTRAOPERATIVE DIATION ONCOLOGY RADIOTHERAPY
	Group T2. Radiation Oncology
	Subgroup 10. Targeted Intraoperative Radiotherapy
	INTRAOPERATIVE RADIOTHERAPY
15900	BREAST, MALIGNANT TUMOUR, targeted intraoperative radiotherapy, using an Intrabeam® device,

T2. RAI	10. TARGETED INTRAOPERATIV
	delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who:
	a) is 45 years of age or more; and
	b) has a T1 or small T2 (less than or equal to 3cm in diameter) primary tumour; and
	c) has an histologic Grade 1 or 2 tumour; and
	d) has an oestrogen-receptor positive tumour; and
	e) has a node negative malignancy; and
	f) is suitable for wide local excision of a primary invasive ductal carcinoma that was diagnosed as unifocal on conventional examination and imaging; and
	g) has no contra-indications to breast irradiation
	<b>Fee:</b> \$254.00 <b>Benefit:</b> 75% = \$190.50
T3. THE	ERAPEUTIC NUCLEAR MEDICINE
	Group T3. Therapeutic Nuclear Medicine
	INTRACAVITY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis, not being a service associated with selective internal radiation therapy or to which item 35404, 35406 or 35408 applies (Anaes.)
16003	(See para TN.3.1 of explanatory notes to this Category) <b>Fee:</b> \$660.90 <b>Benefit:</b> 75% = \$495.70 85% = \$576.20
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique
16006	<b>Fee:</b> \$507.85 <b>Benefit:</b> 75% = \$380.90 85% = \$431.70
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique
16009	<b>Fee:</b> \$346.60 <b>Benefit:</b> 75% = \$259.95 85% = \$294.65
	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32
16012	<b>Fee:</b> \$299.85 <b>Benefit:</b> 75% = \$224.90 85% = \$254.90
	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either:
	(i) the disease is poorly controlled by conventional radiotherapy; or
	(ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain
	<b>Fee:</b> \$4,151.05 <b>Benefit:</b> 75% = \$3113.30 85% = \$4066.35
16015	

T2 TUE	DADELITIC NUCLEAR MEDICINE
13. ITE	RAPEUTIC NUCLEAR MEDICINE    Fee: \$2,481.55   Benefit: 75% = \$1861.20   85% = \$2396.85
T4. OBS	TETRICS
	Group T4. Obstetrics  Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if:
	(a) the attendance is by video conference; and
	(b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
<b>EMSN</b> 16399	(See para TN.4.12 of explanatory notes to this Category)  Derived Fee: 50% of the fee for item 16401,16404,16406,16500,16590 or 16591. Benefit: 85% of the derived fee Extended Medicare Safety Net Cap: \$24.50
	ANTENATAL CARE Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitionerif: (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; (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
<b>EMSN</b> 16400	(See para TN.4.1 of explanatory notes to this Category)  Fee: \$27.70 Benefit: 85% = \$23.55  Extended Medicare Safety Net Cap: \$11.25
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each attendance, other than a second or subsequent attendance in a single course of treatment
<b>EMSN</b> 16401	(See para TN.4.2 of explanatory notes to this Category)  Fee: \$86.90  Benefit: 75% = \$65.20  Extended Medicare Safety Net Cap: \$55.80
	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.
<b>EMSN</b> 16404	(See para AN.0.70, TN.4.2 of explanatory notes to this Category)

T4. OBS	TETRICS
	<b>Fee:</b> \$43.70 <b>Benefit:</b> 75% = \$32.80 85% = \$37.15 <b>Extended Medicare Safety Net Cap:</b> \$33.50
	Antenatal professional attendance, by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy
<b>EMSN</b> 16406	<b>Fee:</b> \$136.10 <b>Benefit:</b> 75% = \$102.10 85% = \$115.70 <b>Extended Medicare Safety Net Cap:</b> \$109.90
	Postnatal professional attendance (other than a service to which any other item applies) if the attendance:
	(a) is by an obstetrician or general practitioner; and
	(b) is in hospital or at consulting rooms; and
	(c) is between 4 and 8 weeks after the birth; and
	(d) lasts at least 20 minutes; and
	(e) includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(f) is for a pregnancy in relation to which a service to which item 82140 applies is not provided Payable once only for a pregnancy
16407	(See para TN.4.13 of explanatory notes to this Category)  Fee: \$72.85  Benefit: 75% = \$54.65 85% = \$61.95  Extended Medicare Safety Net Cap: \$47.40
	Postnatal attendance (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which any other item applies) if the attendance:
	(a) is by:
	(i) a midwife (on behalf of and under the supervision of the medical practitioner who attended the birth); or
	(ii) an obstetrician; or
	(iii) a general practitioner; and
	(b) is between 1 week and 4 weeks after the birth; and
	(c) lasts at least 20 minutes; and
	(d) is for a patient who was privately admitted for the birth; and
	(e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided Payable once only for a pregnancy
16408	Fee: \$54.25 Benefit: 85% = \$46.15 Extended Medicare Safety Net Cap: \$35.30
	ANTENATAL ATTENDANCE
<b>EMSN</b> 16500	(See para TN.4.3 of explanatory notes to this Category)  Fee: \$47.90  Benefit: 75% = \$35.95  Extended Medicare Safety Net Cap: \$33.50

T4. OBS	TETRICS
	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
<b>EMSN</b> 16501	(See para TN.4.3, TN.4.4 of explanatory notes to this Category) <b>Fee:</b> \$142.80 <b>Benefit:</b> 75% = \$107.10 85% = \$121.40 <b>Extended Medicare Safety Net Cap:</b> \$66.95
	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
<b>EMSN</b> 16502	(See para TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$47.90 <b>Benefit:</b> 75% = \$35.95 85% = \$40.75 <b>Extended Medicare Safety Net Cap:</b> \$22.35
	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance
<b>EMSN</b> 16505	(See para TN.4.3 of explanatory notes to this Category)  Fee: \$47.90  Benefit: 75% = \$35.95 85% = \$40.75  Extended Medicare Safety Net Cap: \$22.35
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day
<b>EMSN</b> 16508	(See para TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$47.90 <b>Benefit:</b> 75% = \$35.95 85% = \$40.75 <b>Extended Medicare Safety Net Cap:</b> \$22.35
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance
<b>EMSN</b> 16509	(See para TN.4.3 of explanatory notes to this Category)  Fee: \$47.90  Benefit: 75% = \$35.95 85% = \$40.75  Extended Medicare Safety Net Cap: \$22.35
	CERVIX, purse string ligation of (Anaes.)  (See para TN.4.3 of explanatory notes to this Category)
<b>EMSN</b> 16511	Fee: \$223.45 Benefit: 75% = \$167.60 85% = \$189.95 Extended Medicare Safety Net Cap: \$111.50
	CERVIX, removal of purse string ligature of (Anaes.)
<b>EMSN</b> 16512	(See para TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$64.50 <b>Benefit:</b> 75% = \$48.40 85% = \$54.85 <b>Extended Medicare Safety Net Cap:</b> \$33.50
	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)
<b>EMSN</b> 16514	(See para TN.4.3 of explanatory notes to this Category)  Fee: \$37.25  Benefit: 75% = \$27.95 85% = \$31.70  Extended Medicare Safety Net Cap: \$16.80

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	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the birth and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the birth (Anaes.)
<b>EMSN</b> 16515	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$640.95 <b>Benefit:</b> 75% = \$480.75 <b>85</b> % = \$556.25 <b>Extended Medicare Safety Net Cap:</b> \$178.40
	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.)
<b>EMSN</b> 16518	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$457.85 <b>Benefit:</b> 75% = \$343.40 85% = \$389.20 <b>Extended Medicare Safety Net Cap:</b> \$178.40
	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)
<b>EMSN</b> 16519	(See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$705.05 <b>Benefit:</b> 75% = \$528.80  85% = \$620.35 <b>Extended Medicare Safety Net Cap:</b> \$334.40
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)
<b>EMSN</b> 16520	(See para TN.4.6, TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$640.95
	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days:
	(a) fetal loss;
	(b) multiple pregnancy;
	(c) antepartum haemorrhage that is:
	(i) of greater than 200 ml; or
	(ii) associated with disseminated intravascular coagulation;
	(d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os;
	(e) baby with a birth weight less than or equal to 2,500 g;
	(f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section;
	(g) trial of vaginal breech birth where there has been a planned vaginal breech birth;
<b>EMSN</b> 16522	(h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix);

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- (i) acute fetal compromise evidenced by:
  - (i) scalp pH less than 7.15; or
  - (ii) scalp lactate greater than 4.0;
- (j) acute fetal compromise evidenced by at least one of the following significant cardiotocograph abnormalities:
  - (i) prolonged bradycardia (less than 100 bpm for more than 2 minutes);
  - (ii) absent baseline variability (less than 3 bpm);
  - (iii) sinusoidal pattern;
  - (iv) complicated variable decelerations with reduced (3 to 5 bpm) or absent baseline variability;
  - (v) late decelerations;
- (k) pregnancy induced hypertension of at least 140/90 mm Hg associated with:
  - (i) at least 2+ proteinuria on urinalysis; or
  - (ii) protein-creatinine ratio greater than 30 mg/mmol; or
  - (iii) platelet count less than  $150 \times 10^9$ /L; or
  - (iv) uric acid greater than 0.36 mmol/L;
- (1) gestational diabetes mellitus requiring at least daily blood glucose monitoring;
- (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by:
  - (i) the patient requiring hospitalisation; or
  - (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or
  - (iii) the patient having a GP mental health treatment plan; or
  - (iv) the patient having a management plan prepared in accordance with item 291;
- (n) disclosure or evidence of domestic violence;
- (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation:
  - (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy;
  - (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);
  - (iii) previous renal or liver transplant;
  - (iv) renal dialysis;

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	(v) chronic liver disease with documented oesophageal varices;
	(vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);
	(vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;
	(viii) maternal height of less than 148 cm;
	(ix) a body mass index greater than or equal to 40;
	(x) pre-existing diabetes mellitus on medication prior to pregnancy;
	(xi) thyrotoxicosis requiring medication;
	(xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;
	(xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;
	(xiv) HIV, hepatitis B or hepatitis C carrier status positive;
	(xv) red cell or platelet iso-immunisation;
	(xvi) cancer with metastatic disease;
	(xvii) illicit drug misuse during pregnancy (Anaes.)
	(See para TN.4.7 of explanatory notes to this Category) <b>Fee:</b> \$1,655.40 <b>Benefit:</b> 75% = \$1241.55
	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a pregnancy.
	(Anaes.)
<b>EMSN</b> 16527	(See para TN.4.8 of explanatory notes to this Category) <b>Fee:</b> \$640.95 <b>Benefit:</b> 75% = \$480.75 <b>85</b> % = \$556.25 <b>Extended Medicare Safety Net Cap:</b> \$178.40
	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.)
EMSN 16528	(See para TN.4.8 of explanatory notes to this Category) <b>Fee:</b> \$640.95 <b>Benefit:</b> 75% = \$480.75 <b>Extended Medicare Safety Net Cap:</b> \$334.40
	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)
16530	(See para TN.4.5 of explanatory notes to this Category) <b>Fee:</b> \$390.50 <b>Benefit:</b> 75% = \$292.90 <b>85</b> % = \$331.95 <b>Extended Medicare Safety Net Cap:</b> \$253.85
	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.)
<b>EMSN</b> 16531	(See para TN.4.5, TN.4.14 of explanatory notes to this Category) <b>Fee:</b> \$781.00 <b>Benefit:</b> 75% = \$585.75

T4. OBS	STETRICS
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy
<b>EMSN</b> 16533	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) <b>Fee:</b> \$107.25 <b>Benefit:</b> 75% = \$80.45
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy
<b>EMSN</b> 16534	(See para TN.4.3, TN.4.14 of explanatory notes to this Category)  Fee: \$107.25  Benefit: 75% = \$80.45
	POST-PARTUM CARE EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)
<b>EMSN</b> 16564	(See para TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$221.50
	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.)
<b>EMSN</b> 16567	(See para TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$323.90 <b>Benefit:</b> 75% = \$242.95 85% = \$275.35 <b>Extended Medicare Safety Net Cap:</b> \$222.95
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.)
<b>EMSN</b> 16570	(See para TN.4.10 of explanatory notes to this Category)  Fee: \$422.70  Benefit: 75% = \$317.05  85% = \$359.30  Extended Medicare Safety Net Cap: \$222.95
	CERVIX, repair of extensive laceration or lacerations (Anaes.)
<b>EMSN</b> 16571	(See para TN.4.10 of explanatory notes to this Category)  Fee: \$323.90  Benefit: 75% = \$242.95  Extended Medicare Safety Net Cap: \$222.95
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)
<b>EMSN</b> 16573	(See para TN.4.10 of explanatory notes to this Category) <b>Fee:</b> \$263.95 <b>Benefit:</b> 75% = \$198.00 85% = \$224.40 <b>Extended Medicare Safety Net Cap:</b> \$222.95
	Planning and management, by a practitioner, of a pregnancy if:
	(a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and
	(b) the patient intends to be privately admitted for the birth; and
	(c) the pregnancy has progressed beyond 28 weeks gestation; and
<b>EMSN</b> 16590	(d) the practitioner has maternity privileges at a hospital or birth centre; and

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	(e) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(f) a service to which item 16591 applies is not provided in relation to the same pregnancy
	Payable once only for a pregnancy
	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) <b>Fee:</b> \$378.70 <b>Benefit:</b> 75% = \$284.05 85% = \$321.90 <b>Extended Medicare Safety Net Cap:</b> \$222.95
	Planning and management, by a practitioner, of a pregnancy if:
	(a) the pregnancy has progressed beyond 28 weeks gestation; and
	(b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and
	(c) a service to which item 16590 applies is not provided in relation to the same pregnancy
	Payable once only for a pregnancy
<b>EMSN</b> 16591	(See para TN.4.13, TN.4.9 of explanatory notes to this Category) <b>Fee:</b> \$144.95 <b>Benefit:</b> 75% = \$108.75  85% = \$123.25 <b>Extended Medicare Safety Net Cap:</b> \$111.50
	INTERVENTIONAL TECHNIQUES
	AMNIOCENTESIS, diagnostic
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)
EMSN 16600	<b>Fee:</b> \$64.50 <b>Benefit:</b> 75% = \$48.40 85% = \$54.85 <b>Extended Medicare Safety Net Cap:</b> \$33.50
	CHORIONIC VILLUS SAMPLING, by any route
EMSN	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$123.80 <b>Benefit:</b> 75% = \$92.85 85% = \$105.25
16603	Extended Medicare Safety Net Cap: \$66.95  Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)
<b>EMSN</b> 16606	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)  Fee: \$247.15  Benefit: 75% = \$185.40 85% = \$210.10  Extended Medicare Safety Net Cap: \$133.85
	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.)
<b>EMSN</b> 16609	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$503.95 <b>Benefit:</b> 75% = \$378.00 85% = \$428.40 <b>Extended Medicare Safety Net Cap:</b> \$256.45
16612	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with

T4. OBS	TETRICS
	service described in item 16609 (Anaes.)
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$396.50 <b>Benefit:</b> 75% = \$297.40  85% = \$337.05
	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)
16615	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$211.20 <b>Benefit:</b> 75% = \$158.40 85% = \$179.55
	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated
<b>EMSN</b> 16618	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)  Fee: \$211.20  Benefit: 75% = \$158.40 85% = \$179.55  Extended Medicare Safety Net Cap: \$105.95
	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios
16621	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$211.20 <b>Benefit:</b> 75% = \$158.40 85% = \$179.55
	FOETAL FLUID FILLED CAVITY, drainage of
EMSN 16624	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$303.90 <b>Benefit:</b> 75% = \$227.95 85% = \$258.35 <b>Extended Medicare Safety Net Cap:</b> \$144.95
	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis
<b>EMSN</b> 16627	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) <b>Fee:</b> \$618.70 <b>Benefit:</b> 75% = \$464.05 85% = \$534.00 <b>Extended Medicare Safety Net Cap:</b> \$312.15
T6. ANA	ESTHETICS 1. ANAESTHESIA CONSULTATIONS
	Group T6. Anaesthetics
	Subgroup 1. Anaesthesia Consultations
	Professional attendance on a patient by a specialist practising in his or her specialty of anaesthesia if:
	(a) the attendance is by video conference; and
	(b) item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
17609	(B) at the time of the attendance-at least 15 kms by road from the specialist; or

T6. ANAESTHETICS		1. ANAESTHESIA CONSULTATIONS
	(ii) is a care recipient in a resid	ential care service; or
	(iii) is a patient of:	
	(A) an Aboriginal Medical	Service; or
	(B) an Aboriginal Commun	nity Controlled Health Service;
	for which a direction made	under subsection 19 (2) of the Act applies
	of the derived fee	s Category) 10, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% 300% of the Derived fee for this item, or \$500.00, whichever is the lesser
		, PRE-ANAESTHESIA CONSULTATION
	(Professional attendance by a medical p	ractitioner in the practice of ANAESTHESIA)
	- a BRIEF consultation involving a ta respiratory system)	rgeted history and limited examination (including the cardio-
	- AND of not more than 15 minutes so items 2801 - 3000 apply	duration, not being a service associated with a service to which
17610	(See para TN.6.1 of explanatory notes to thin Fee: \$44.35 Benefit: 75% = \$33 Extended Medicare Safety Net Cap: \$35	3.30 85% = \$37.70
	patient undergoing advanced surge history and an extensive examinati management plan documented in t	actitioner in the practice of anaesthesia for a consultation on a cry or who has complex medical problems, involving a selective on of multiple systems and the formulation of a written patient he patient notes - and of more than 15 minutes but not more than ervice associated with a service to which items 2801 - 3000
17615	(See para TN.6.1 of explanatory notes to thi <b>Fee:</b> \$88.25 <b>Benefit:</b> 75% = \$66 <b>Extended Medicare Safety Net Cap:</b> \$60	5.20 85% = \$75.05
	patient undergoing advanced surge history and comprehensive examin management plan documented in t	ractitioner in the practice of anaesthesia for a consultation on a cry or who has complex medical problems involving a detailed ation of multiple systems and the formulation of a written patient he patient notes - and of more than 30 minutes but not more than ervice associated with a service to which items 2801 - 3000 apply
17620	(See para TN.6.1 of explanatory notes to thi <b>Fee:</b> \$122.20 <b>Benefit:</b> 75% = \$9 <b>Extended Medicare Safety Net Cap:</b>	1.65 85% = \$103.90
17625	-	actitioner in the practice of anaesthesia for a consultation on a

T6. AN	AESTHETICS 1. ANAESTHESIA CONSULTATIONS
	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/of 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 TN.6.1 of explanatory notes to this Category)  Fee: \$155.60  Benefit: 75% = \$116.70 85% = \$132.30  Extended Medicare Safety Net Cap: \$466.80
	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)
	(Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patien is referred to him or her)
	- a BRIEF consultation involving a short history and limited examination
	- <i>AND of not more than 15 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply
17640	(See para TN.6.2 of explanatory notes to this Category)  Fee: \$44.35  Benefit: 75% = \$33.30 85% = \$37.70  Extended Medicare Safety Net Cap: \$133.05
	- a consultation involving a selective history and examination of multiple systems and the formulation of a written patient management plan
	- <i>AND of more than 15 minutes but not more than 30 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply.
17645	(See para TN.6.2 of explanatory notes to this Category)  Fee: \$88.25  Benefit: 75% = \$66.20 85% = \$75.05  Extended Medicare Safety Net Cap: \$264.75
	- 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
17650	(See para TN.6.2 of explanatory notes to this Category) <b>Fee:</b> \$122.20 <b>Benefit:</b> 75% = \$91.65 85% = \$103.90 <b>Extended Medicare Safety Net Cap:</b> \$366.60
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

T6. ANAESTHETICS	1. ANAESTHESIA CONSULTATIONS
professiona	ls and/or the patient, involving medical planning of high complexity,
- <i>AND of</i> 2801 - 3000	more than 45 minutes duration, not being a service associated with a service to which items apply.
Fee: \$155.6	J.6.2 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$116.70 85% = \$132.30 <b>Medicare Safety Net Cap:</b> \$466.80
	ANAESTHETIST, CONSULTATION, OTHER
(Profession	al attendance by an anaesthetist in the practice of ANAESTHESIA)
where no p	tation immediately prior to the institution of a major regional blockade in a patient in labour, revious anaesthesia consultation has occurred, not being a service associated with a service to s 2801 - 3000 apply.
Fee: \$88.25	N.6.3 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$66.20  85% = \$75.05 <b>Medicare Safety Net Cap:</b> \$264.75
- Where a rooms if:	a pre-anaesthesia consultation covered by an item in the range 17615-17625 is performed in-
(a) the serv	ice is provided to a patient prior to an admitted patient episode of care involving anaesthesia;
(b) the serv	ice is not provided to an admitted patient of a hospital; and
	ice is not provided on the day of admission to hospital for the subsequent episode of care naesthesia services; and
(d) the serv	ice is of more than 15 minutes duration
not being a	service associated with a service to which items 2801 - 3000 apply.
Fee: \$40.80	N.6.3 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$30.60 85% = \$34.70 <b>Medicare Safety Net Cap:</b> \$122.40

T7. RE0	GIONAL OR FIELD NERVE BLOCKS
	Group T7. Regional Or Field Nerve Blocks
	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion
18213	<b>Fee:</b> \$90.05 <b>Benefit:</b> 75% = \$67.55 85% = \$76.55
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner
	Applicable once per presentation, per medical practitioner, per complete new procedure (Anaes.)
18216	(See para TN.10.7 of explanatory notes to this Category) <b>Fee:</b> \$192.95 <b>Benefit:</b> 75% = \$144.75  85% = \$164.05
	Intrathecal, combined spinal-epidural or epidural infusion of a therapeutic substance, initial injection or commencement of, if continuous attendance by the medical practitioner extends beyond the first hour (Anaes.)
18219	<b>Derived Fee:</b> The fee for item 18216 plus \$19.30 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less
18222	(See para TN.7.2, TN.10.7 of explanatory notes to this Category) <b>Fee:</b> \$38.25 <b>Benefit:</b> 75% = \$28.70 85% = \$32.55
	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes
18225	(See para TN.7.2, TN.10.7 of explanatory notes to this Category) <b>Fee:</b> \$50.85 <b>Benefit:</b> 75% = \$38.15 85% = \$43.25
	Intrathecal, combined spinal-epidural 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.
	Applicable once per presentation, per medical practitioner, per complete new procedure
18226	(See para TN.7.4, TN.10.7 of explanatory notes to this Category) <b>Fee:</b> \$289.35 <b>Benefit:</b> 75% = \$217.05  85% = \$245.95
	Intrathecal, combined spinal-epidural 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.
19227	(See para TN.7.4, TN.10.7 of explanatory notes to this Category) <b>Derived Fee:</b> The fee for item 18226 plus \$29.05 for each additional 15 minutes or part there of beyond the first
18227	hour of attendance by the medical practitioner.  INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance
18228	Fee: \$63.50 Benefit: 75% = \$47.65 85% = \$54.00
10220	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)
18230	<b>Fee:</b> \$242.25 <b>Benefit:</b> 75% = \$181.70 85% = \$205.95

T7. RE0	GIONAL OR FIELD NERVE BLOCKS
	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.)
18232	(See para TN.7.3 of explanatory notes to this Category) <b>Fee:</b> \$192.95 <b>Benefit:</b> 75% = \$144.75  85% = \$164.05
	EPIDURAL INJECTION of blood for blood patch (Anaes.)
18233	<b>Fee:</b> \$192.95 <b>Benefit:</b> 75% = \$144.75 85% = \$164.05
	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)
18234	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$126.85
	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)
18236	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$63.50 <b>Benefit:</b> 75% = \$47.65 85% = \$54.00
	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies
18238	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$38.25 <b>Benefit:</b> 75% = \$28.70 85% = \$32.55
	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent
18240	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$95.10 <b>Benefit:</b> 75% = \$71.35 85% = \$80.85
	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)
18242	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$38.25 <b>Benefit:</b> 75% = \$28.70 85% = \$32.55
	VAGUS NERVE, injection of an anaesthetic agent
18244	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$102.40 <b>Benefit:</b> 75% = \$76.80 85% = \$87.05
	PHRENIC NERVE, injection of an anaesthetic agent
18248	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$90.05 <b>Benefit:</b> 75% = \$67.55  85% = \$76.55
	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent
18250	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$63.50 <b>Benefit:</b> 75% = \$47.65 85% = \$54.00
	CERVICAL PLEXUS, injection of an anaesthetic agent
18252	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$102.40 <b>Benefit:</b> 75% = \$76.80 85% = \$87.05
	BRACHIAL PLEXUS, injection of an anaesthetic agent
18254	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$102.40 <b>Benefit:</b> 75% = \$76.80 85% = \$87.05
_ <del></del>	SUPRASCAPULAR NERVE, injection of an anaesthetic agent
18256	(See para TN.7.5 of explanatory notes to this Category)

GIONAL OR FIELD NERVE BLOCKS
<b>Fee:</b> \$63.50 <b>Benefit:</b> 75% = \$47.65 85% = \$54.00
INTERCOSTAL NERVE (single), injection of an anaesthetic agent
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$63.50 <b>Benefit:</b> 75% = \$47.65  85% = \$54.00
INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$90.05 <b>Benefit:</b> 75% = \$67.55  85% = \$76.55
ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.)
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$63.50 <b>Benefit:</b> 75% = \$47.65 85% = \$54.00
PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$102.40
ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$63.50 <b>Benefit:</b> 75% = \$47.65 85% = \$54.00
OBTURATOR NERVE, injection of an anaesthetic agent
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$90.05 <b>Benefit:</b> 75% = \$67.55  85% = \$76.55
FEMORAL NERVE, injection of an anaesthetic agent
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$90.05 <b>Benefit:</b> 75% = \$67.55  85% = \$76.55
SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$63.50 <b>Benefit:</b> 75% = \$47.65 85% = \$54.00
PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$90.05 <b>Benefit:</b> 75% = \$67.55 85% = \$76.55
PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$126.85
SCIATIC NERVE, injection of an anaesthetic agent
(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$90.05 <b>Benefit:</b> 75% = \$67.55  85% = \$76.55
SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.)
(See para TN.7.5 of explanatory notes to this Category)

	<b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15 85% = \$107.85
	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure
18282	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$102.40 <b>Benefit:</b> 75% = \$76.80 85% = \$87.05
	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)
18284	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$150.00 <b>Benefit:</b> 75% = \$112.50  85% = \$127.50
	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)
	(See para TN.7.5 of explanatory notes to this Category)
18286	<b>Fee:</b> \$150.00 <b>Benefit:</b> 75% = \$112.50 85% = \$127.50
	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)
18288	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$150.00 <b>Benefit:</b> 75% = \$112.50 85% = \$127.50
10200	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a
	service associated with the injection of botulinum toxin (Anaes.)
18290	<b>Fee:</b> \$253.75 <b>Benefit:</b> 75% = \$190.35 85% = \$215.70
	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.)
18292	(See para TN.7.5 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15  85% = \$107.85
	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)
18294	<b>Fee:</b> \$178.80 <b>Benefit:</b> 75% = \$134.10 85% = \$152.00
	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)
18296	<b>Fee:</b> \$152.95 <b>Benefit:</b> 75% = \$114.75 85% = \$130.05
10270	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner
18297	Fee: \$60.30 Benefit: 75% = \$45.25 85% = \$51.30
10297	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)
18298	Fee: \$178.80 Benefit: 75% = \$134.10 85% = \$152.00
	GICAL OPERATIONS 1. GENERAL
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	7 /
	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

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	<b>Derived Fee:</b> 50% of the fee which would have applied had the procedure not been disco	ontinued
	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at was performed, including any associated consultation	which the procedure is
30003	<b>Fee:</b> \$36.90 <b>Benefit:</b> 75% = \$27.70 85% = \$31.40	
	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) which the procedure is performed, including any associated consultation	each attendance at
30006	<b>Fee:</b> \$47.25 <b>Benefit:</b> 75% = \$35.45 85% = \$40.20	
	LOCALISED BURNS, dressing of, under general anaesthesia (not involving graf	ting) (Anaes.)
30010	<b>Fee:</b> \$75.10 <b>Benefit:</b> 75% = \$56.35	
	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving graf	ting) (Anaes.)
30014	<b>Fee:</b> \$157.90 <b>Benefit:</b> 75% = \$118.45	
	BURNS, excision of, under general anaesthesia, involving not more than 10 per c where grafting is not carried out during the same operation (Anaes.) (Assist.)	ent of body surface,
30017	<b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45 85% = \$281.60	
	BURNS, excision of, under general anaesthesia, involving more than 10 per cent grafting is not carried out during the same operation (Anaes.) (Assist.)	of body surface, where
30020	<b>Fee:</b> \$645.15 <b>Benefit:</b> 75% = \$483.90	
	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debrid general anaesthesia or regional or field nerve block, including suturing of that wo (Anaes.) (Assist.)	
30023	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45  85% = \$281.60	
	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical in Gangrene, under general anaesthesia or regional or field nerve block, including su when performed (Anaes.) (Assist.)	
30024	<b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45 85% = \$281.60	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.)	
30026	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$53.05 <b>Benefit:</b> 75% = \$39.80 85% = \$45.10	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR other than wound closure at time of surgery, not on face or neck, small (NOT MC LONG), involving deeper tissue, not being a service to which another item in Gro	RE THAN 7 CM
30029	(See para TN.8.6 of explanatory notes to this Category) <b>Fee:</b> \$91.45 <b>Benefit:</b> 75% = \$68.60 85% = \$77.75	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR other than wound closure at time of surgery, on face or neck, small (NOT MORE superficial (Anaes.)	
	(See para TN.8.6 of explanatory notes to this Category)	

T8. SUF	. SURGICAL OPERATIONS 1. 0			
	Fee: \$83.80	<b>Benefit:</b> 75% = \$62.85 85% = \$71.25		
	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.)			
30035	(See para TN.8.6 <b>Fee:</b> \$119.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$89.60 85% = \$101.55		
	other than woul	BCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPA nd closure at time of surgery, not on face or neck, large (MORE being a service to which another item in Group T4 applies (Ana	THAN 7 CM LONG),	
30038	(See para TN.8.6 <b>Fee:</b> \$91.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$68.60 85% = \$77.75		
	other than woul	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, other than on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, other than a service to which another item in Group T4 applies		
30042	(See para TN.8.6 <b>Fee:</b> \$188.55	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$141.45 85% = \$160.30		
		BCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAnd closure at time of surgery, on face or neck, large (MORE TH. nes.)		
30045	(See para TN.8.6 <b>Fee:</b> \$119.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$89.60 85% = \$101.55		
	other than woul	BCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIND CLOSURE at time of surgery, on face or neck, large (MORE THE per tissue (Anaes.)		
30049	(See para TN.8.6 <b>Fee:</b> \$188.55	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$141.45 85% = \$160.30		
		NESS LACERATION OF EAR, EYELID, NOSE OR LIP, repairch layer of tissue (Anaes.) (Assist.)	r of, with accurate	
30052	Fee: \$258.05	<b>Benefit:</b> 75% = \$193.55 85% = \$219.35		
		ESSING OF, under general anaesthesia, with or without remove ed with a service to which another item in this Group applies (A	_	
30055	Fee: \$75.10	<b>Benefit:</b> 75% = \$56.35 85% = \$63.85		
	POSTOPERAT procedure (Ana	TVE HAEMORRHAGE, control of, under general anaesthesia, es.)	as an independent	
30058	Fee: \$146.65	<b>Benefit:</b> 75% = \$110.00 85% = \$124.70		
		FOREIGN BODY, REMOVAL OF, (including from cornea or occdure (Anaes.)	sclera), as an	
30061	Fee: \$23.90	<b>Benefit:</b> 75% = \$17.95 85% = \$20.35		
		bcutaneous implant, removal of, as an independent procedure (A	anaes.)	

T8. SUF	RGICAL OPERAT	ONS 1. GENER	RAL
		US FOREIGN BODY, removal of, requiring incision and exploration, including closormed, as an independent procedure (Anaes.)	sure
30064	Fee: \$111.65	<b>Benefit:</b> 75% = \$83.75 85% = \$94.95	
	FOREIGN BOD procedure (Anae	Y IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent, (Assist.)	ent
30068	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95 85% = \$239.10	
	examination (An		al
30071	<b>Fee:</b> \$53.05	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$39.80  85% = \$45.10 <b>care Safety Net Cap:</b> \$42.45	
		y of mucous membrane, as an independent procedure, if the biopsy specimen is sent mination (Anaes.)	for
30072	(See para TN.8.7 o <b>Fee:</b> \$53.05	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$39.80  85% = \$45.10	
	DIAGNOSTIC E	SIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, a rocedure, if the biopsy specimen is sent for pathological examination (Anaes.)	as
30075	Fee: \$152.15	<b>Benefit:</b> 75% = \$114.15 85% = \$129.35	
	procedure, where	ORILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORGAN, as an independent the biopsy specimen is sent for pathological examination (Anaes.)	nt
30078	(See para TN.8.7 o <b>Fee:</b> \$49.25	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$36.95  85% = \$41.90	
		SIOPSY OF BONE MARROW by trephine using open approach, where the biopsy for pathological examination (Anaes.)	
30081	(See para TN.8.7 o <b>Fee:</b> \$111.65	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$83.75 85% = \$94.95	
		SIOPSY OF BONE MARROW by trephine using percutaneous approach where the pathological examination (Anaes.)	
30084	(See para TN.8.7 o <b>Fee:</b> \$59.75	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$44.85 85% = \$50.80	
		BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL where the biopsy is sent for pathological examination (Anaes.)	
30087	(See para TN.8.7 o <b>Fee:</b> \$29.90	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$22.45  85% = \$25.45	
		SIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, who for pathological examination (Anaes.)	nere
30090	(See para TN.8.7 o <b>Fee:</b> \$130.60	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$97.95 85% = \$111.05	
	DIAGNOSTIC N examination (An	IEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological aes.)	
30093	(See para TN.8.7 o	f explanatory notes to this Category)	

T8. SUF	RGICAL OPERAT	TIONS 1. GENERAL
	Fee: \$174.30	<b>Benefit:</b> 75% = \$130.75 85% = \$148.20
		PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging not including imaging, where the biopsy is sent for pathological examination (Anaes.)
30094	(See para TN.8.7 <b>Fee:</b> \$192.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$144.35 85% = \$163.60
		SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for amination (Anaes.)
30096	(See para TN.8.7 <b>Fee:</b> \$186.85	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$140.15 85% = \$158.85
		nance of a Synacthen Stimulation Test, including associated consultation; by a medical a resuscitation training and access to facilities where life support procedures can be
	greater	cortisol at 0830-0930 hours on any day in the preceding month has been measured at than 100 nmol/L but less than 400 nmol/L; or
	b. in a par	tient who is acutely unwell and adrenal insufficiency is suspected.
30097	(See para TN.8.13 <b>Fee:</b> \$98.70	89 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$74.05  85% = \$83.90
	SINUS, excision	n of, involving superficial tissue only (Anaes.)
30099	Fee: \$91.45	<b>Benefit:</b> 75% = \$68.60 85% = \$77.75
	SINUS, excision	n of, involving muscle and deep tissue (Anaes.)
30103	Fee: \$186.85	<b>Benefit:</b> 75% = \$140.15 85% = \$158.85
	PRE-AURICUI	AR SINUS, on a person 10 years of age or over. Excision of, (Anaes.)
30104	Fee: \$128.95	<b>Benefit:</b> 75% = \$96.75 85% = \$109.65
		AR SINUS, on a person under 10 years of age. Excision of, (Anaes.)
30105	<b>Fee:</b> \$167.60	<b>Benefit:</b> 75% = \$125.70 85% = \$142.50
	GANGLION OR SMALL BURSA, excision of, other than a service associated with a service to which another item in this Group applies (Anaes.)	
30107	Fee: \$223.45	<b>Benefit:</b> 75% = \$167.60 85% = \$189.95
	BURSA (LARC (Assist.)	E), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.)
30111	Fee: \$377.45	<b>Benefit:</b> 75% = \$283.10 85% = \$320.85
	BURSA, SEMII	MEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.)
30114	Fee: \$377.45	<b>Benefit:</b> 75% = \$283.10
	not being a serv	ge excision of abdominal apron that is a direct consequence of significant weight loss, ice associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45565 applies, if:
30165		trigo or another skin condition that risks loss of skin integrity and has failed 3 months of non surgical) treatment; and

T8. SUR	GICAL OPERATIONS	1. GENERAL
	(b) the abdominal apron interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prolipectomy	rior to the
	(H) (Anaes.) (Assist.)	
	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$462.15 <b>Benefit:</b> 75% = \$346.65	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct co significant weight loss, not being a service associated with a service to which item 30 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has a conventional (or non surgical) treatment; and	Failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prolipectomy; and	rior to the
	(d) the procedure involves 1 excision only	
	(H) (Anaes.) (Assist.)	
30168	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$462.15 <b>Benefit:</b> 75% = \$346.65	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct co significant weight loss, not being a service associated with a service to which item 301 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has a conventional (or non surgical) treatment; and	Failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
	(c) the weight has been stable for at least 6 months following significant weight loss prolipectomy; and	rior to the
	(d) the procedure involves 2 excisions only	
	(H) (Anaes.) (Assist.)	
30171	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$702.80 <b>Benefit:</b> 75% = \$527.10	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct co significant weight loss, not being a service associated with a service to which item 301 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:	
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has a conventional (or non surgical) treatment; and	Failed 3 months of
	(b) the redundant skin and fat interferes with the activities of daily living; and	
30172	(c) the weight has been stable for at least 6 months following significant weight loss pr	rior to the

T8. SUR	GICAL OPERATIONS 1. GENERAL
	lipectomy; and
	(d) the procedure involves 3 or more excisions
	(H) (Anaes.) (Assist.)
	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$702.80 <b>Benefit:</b> 75% = \$527.10
	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 associated with a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 45564 or 45565 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour surgically removed (Anaes.) (Assist.)
30176	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$1,001.45 <b>Benefit:</b> 75% = \$751.10
	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30179, 45530, 45564 or 45565 applies, if:
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and
	(b) the redundant skin and fat interferes with the activities of daily living; and
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy
	(H) (Anaes.) (Assist.)
30177	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$1,001.45 <b>Benefit:</b> 75% = \$751.10
	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty (Pitanguy type or similar), not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if:
	(a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and
	(b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy
	(H) (Anaes.) (Assist.)
30179	(See para TN.8.8 of explanatory notes to this Category) <b>Fee:</b> \$1,232.55 <b>Benefit:</b> 75% = \$924.45
JU1/7	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.)
30180	Fee: \$138.70 Benefit: 75% = \$104.05 85% = \$117.90

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.)
30183	<b>Fee:</b> \$250.45 <b>Benefit:</b> 75% = \$187.85 85% = \$212.90
	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.)
30187	(See para TN.8.9 of explanatory notes to this Category) <b>Fee:</b> \$261.05
	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 (H) (Anaes.)
30189	(See para TN.8.9 of explanatory notes to this Category) <b>Fee:</b> \$149.65 <b>Benefit:</b> 75% = \$112.25
	Angiofibromas, trichoepitheliomas or other severely disfiguring tumours of the face or neck (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), suitable for laser ablation as confirmed by the opinion of a specialist in the specialty of dermatology—removal of, by carbon dioxide laser or erbium laser ablation, including associated resurfacing (10 or more tumours) (Anaes.)
30190	<b>Fee:</b> \$404.10 <b>Benefit:</b> 75% = \$303.10 85% = \$343.50
	Angiofibromas, trichoepithelioma, epidermal naevi, xanthelasma, pyogenic granuloma, genital angiokeratomas, hereditary haemorrhagic telangiectasia and other severely disfiguring or recurrently bleeding tumours (excluding melanocytic naevi, sebaceous hyperplasia, dermatosis papulosa nigra, Campbell De Morgan angiomas and seborrheic or viral warts), treatment of, with carbon dioxide/erbium or other appropriate laser (or curettage and fine point diathermy for pyogenic granuloma only), if confirmed by the opinion of a specialist in the specialty of dermatology, one or more lesions.
30191	<b>Fee:</b> \$64.50 <b>Benefit:</b> 75% = \$48.40 85% = \$54.85
	PREMALIGNANT SKIN LESIONS (including solar keratoses), treatment of, by ablative technique (10 or more lesions) (Anaes.)
30192	(See para TN.8.9 of explanatory notes to this Category) <b>Fee:</b> \$40.20 <b>Benefit:</b> 75% = \$30.15 85% = \$34.20
	Malignant neoplasm of skin or mucous membrane that has been:
	(a) proven by histopathology; or
	(b) confirmed by the opinion of a specialist in the specialty of dermatology where a specimen has been submitted for histologic confirmation;
	removal of, by serial curettage, or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy (Anaes.)
30196	(See para TN.8.10 of explanatory notes to this Category) <b>Fee:</b> \$128.30 <b>Benefit:</b> 75% = \$96.25 85% = \$109.10
_	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinior of a specialist in the specialty of dermatology—removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles
30202	(See para TN.8.10 of explanatory notes to this Category) <b>Fee:</b> \$49.10 <b>Benefit:</b> 75% = \$36.85 85% = \$41.75

RGICAL OPERATI	IONS	1. GENERAL
Skin lesions, mul	Itiple injections with glucocorticoid preparations (Anaes.)	
Fee: \$45.30	<b>Benefit:</b> 75% = \$34.00 85% = \$38.55	
		s, if undertaken
Fee: \$165.55	<b>Benefit:</b> 75% = \$124.20	
НАЕМАТОМА,	aspiration of (Anaes.)	
Fee: \$27.80	<b>Benefit:</b> 75% = \$20.85 85% = \$23.65	
· ·	1	g admission to
(See para TN.8.4 o <b>Fee:</b> \$27.80	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$20.85  85% = \$23.65	
(See para TN.8.4 o <b>Fee:</b> \$165.55	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$124.20	
		niques - but
Fee: \$241.40	<b>Benefit:</b> 75% = \$181.05 85% = \$205.20	
		at not including
Fee: \$271.95	<b>Benefit:</b> 75% = \$204.00 85% = \$231.20	
MUSCLE, excisi	ion of (LIMITED), or fasciotomy (Anaes.)	
Fee: \$152.15	<b>Benefit:</b> 75% = \$114.15 85% = \$129.35	
MUSCLE, excisi	ion of (EXTENSIVE) (Anaes.) (Assist.)	
Fee: \$277.30	<b>Benefit:</b> 75% = \$208.00 85% = \$235.75	
MUSCLE, RUPT	TURED, repair of (limited), not associated with external wound (Anaes.)	
Fee: \$227.20	<b>Benefit:</b> 75% = \$170.40 85% = \$193.15	
MUSCLE, RUPT	TURED, repair of (extensive), not associated with external wound (Anaes	s.) (Assist.)
Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35 85% = \$255.40	
FASCIA, DEEP,	repair of, FOR HERNIATED MUSCLE (Anaes.)	-
Fee: \$152.15	<b>Benefit:</b> 75% = \$114.15 85% = \$129.35	
		this Group
Fee: \$362.05	<b>Benefit:</b> 75% = \$271.55 85% = \$307.75	
	CESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)	
	<b>Benefit:</b> 75% = \$271.55	
	Skin lesions, multiple Fee: \$45.30  Keloid and other in the operating to Fee: \$165.55  HAEMATOMA, Fee: \$27.80  HAEMATOMA, a hospital - INCI (See para TN.8.4 or Fee: \$27.80  LARGE HAEMA requiring admiss (See para TN.8.4 or Fee: \$165.55  PERCUTANEON not including imate Fee: \$165.55  PERCUTANEON not including imate Fee: \$241.40  ABSCESS DRA imaging (Anaes.) Fee: \$271.95  MUSCLE, excision Fee: \$152.15  MUSCLE, excision Fee: \$277.30  MUSCLE, RUPTE Fee: \$227.20  MUSCLE, RUPTE Fee: \$300.45  FASCIA, DEEP, Fee: \$152.15  BONE TUMOU applies (Anaes.) Fee: \$362.05	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)  Fee: \$45.30  Benefit: 75% = \$34.00  85% = \$38.55  Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparation in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.)  Fee: \$165.55  Benefit: 75% = \$124.20  HAEMATOMA, aspiration of (Anaes.)  Fee: \$27.80  Benefit: 75% = \$20.85  85% = \$23.65  HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)  (See para TN.8.4 of explanatory notes to this Category)  Fee: \$27.80  Benefit: 75% = \$20.85  EARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar I requiring admission to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare)  (See para TN.8.4 of explanatory notes to this Category)  Fee: \$165.55  Benefit: 75% = \$124.20  PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging technot including imaging (Anaes.)  Fee: \$241.40  Benefit: 75% = \$181.05  85% = \$205.20  ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - buinaging (Anaes.)  Fee: \$152.15  Benefit: 75% = \$114.15  85% = \$129.35  MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.)  Fee: \$277.30  Benefit: 75% = \$114.15  85% = \$129.35  MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.)  Fee: \$227.20  Benefit: 75% = \$208.00  85% = \$235.75  MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.)  Fee: \$227.20  Benefit: 75% = \$170.40  85% = \$193.15  MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.)  Fee: \$227.20  Benefit: 75% = \$208.00  85% = \$255.40  FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.)  Fee: \$152.15  Benefit: 75% = \$114.15  85% = \$129.35  BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in applies (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	IONS 1. GENERAL		
	PAROTID DUC	T, repair of, using micro-surgical techniques (Anaes.) (Assist.)		
30246	Fee: \$700.85	<b>Benefit:</b> 75% = \$525.65		
	PAROTID GLAI	ND, total extirpation of (Anaes.) (Assist.)		
30247	Fee: \$751.20	<b>Benefit:</b> 75% = \$563.40		
30247		ND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)		
20250				
30250	Fee: \$1,271.10	<b>Benefit:</b> 75% = \$953.35  AROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.)		
		•		
30251	Fee: \$1,952.50	<b>Benefit:</b> 75% = \$1464.40  85% = \$1867.80		
	(Assist.)	ND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.)		
30253	Fee: \$847.40	<b>Benefit:</b> 75% = \$635.55		
	SUBMANDIBU	LAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)		
30255	Fee: \$1,128.40	<b>Benefit:</b> 75% = \$846.30		
	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.)			
30256	Fee: \$452.55	<b>Benefit:</b> 75% = \$339.45		
		GLAND, extirpation of (Anaes.)		
30259	Fee: \$201.70	<b>Benefit:</b> 75% = \$151.30 85% = \$171.45		
		AND, DILATATION OR DIATHERMY of duct (Anaes.)		
30262	Fee: \$59.75	<b>Benefit:</b> 75% = \$44.85 85% = \$50.80		
30202		emoval of calculus from duct or meatotomy or marsupialisation, 1 or more such		
	procedures. (Ana	· · · · · · · · · · · · · · · · · · ·		
30266	Fee: \$152.15	<b>Benefit:</b> 75% = \$114.15 85% = \$129.35		
	SALIVARY GLA	AND, repair of CUTANEOUS FISTULA OF (Anaes.)		
30269	Fee: \$152.15	<b>Benefit:</b> 75% = \$114.15 85% = \$129.35		
	TONGUE, partia	al excision of (Anaes.) (Assist.)		
30272	Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35 85% = \$255.40		
00272		ISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE		
	AND LYMPH N	ODES OF NECK (commandotype operation) (Anaes.) (Assist.)		
30275	Fee: \$1,790.95	<b>Benefit:</b> 75% = \$1343.25		
	TONGUE TIE, r	epair of, not being a service to which another item in this Group applies (Anaes.)		
30278	Fee: \$47.25	<b>Benefit:</b> 75% = \$35.45 85% = \$40.20		
	TONGUE TIE, N	MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person over, under general anaesthesia (Anaes.)		
20201	Fee: \$121.40	<b>Benefit:</b> 75% = \$91.05 85% = \$103.20		
30281	rec. \$121.40	<b>Denotit.</b> $1370 - $91.03$ $0370 = $103.20$		

	RGICAL OPERATIONS	1. GENERAL
	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.)	
30283	<b>Fee:</b> \$208.00 <b>Benefit:</b> 75% = \$156.00 85% = \$176.80	
	BRANCHIAL CYST, on a person 10 years of age or over. Removal of, (A	Anaes.) (Assist.)
30286	<b>Fee:</b> \$404.20 <b>Benefit:</b> 75% = \$303.15 85% = \$343.60	
	BRANCHIAL CYST, on a person under 10 years of age. Removal of, (Ar	naes.) (Assist.)
30287	<b>Fee:</b> \$525.50 <b>Benefit:</b> 75% = \$394.15 85% = \$446.70	
	BRANCHIAL FISTULA, on a person 10 years of age or over. Removal or	f, (Anaes.) (Assist.)
30289	<b>Fee:</b> \$510.30 <b>Benefit:</b> 75% = \$382.75	
	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESO without plastic repair (Anaes.) (Assist.)	OPHAGOSTOMY with or
30293	<b>Fee:</b> \$452.55 <b>Benefit:</b> 75% = \$339.45 85% = \$384.70	
	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagosto reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy ar (Anaes.) (Assist.)	
30294	<b>Fee:</b> \$1,790.95 <b>Benefit:</b> 75% = \$1343.25	
	THYROIDECTOMY, total (Anaes.) (Assist.)	
30296	(See para TN.8.137 of explanatory notes to this Category) <b>Fee:</b> \$1,040.10 <b>Benefit:</b> 75% = \$780.10	
	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.	)
30297	(See para TN.8.138 of explanatory notes to this Category) <b>Fee:</b> \$1,040.10 <b>Benefit:</b> 75% = \$780.10	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, in axilla, using preoperative lymphoscintigraphy and lymphotropic dye inject associated with a service to which item 30300, 30302 or 30303 applies (Ar	ion, not being a service
30299	(See para TN.8.12 of explanatory notes to this Category) <b>Fee:</b> \$647.65 <b>Benefit:</b> 75% = \$485.75	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, in II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye associated with a service to which item 30299, 30302 or 30303 applies (Ar	injection, not being a service
30300	(See para TN.8.12 of explanatory notes to this Category) <b>Fee:</b> \$777.15 <b>Benefit:</b> 75% = \$582.90	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, in axilla, using lymphotropic dye injection, not being a service associated wit 30299, 30300 or 30303 applies (Anaes.) (Assist.)	
30302	(See para TN.8.12 of explanatory notes to this Category) <b>Fee:</b> \$518.10 <b>Benefit:</b> 75% = \$388.60	
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, in II/III axilla, using lymphotropic dye injection, not being a service associate item 30299, 30300 or 30302 applies (Anaes.) (Assist.)	
30303	(See para TN.8.12 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS 1.	GENERAL
	<b>Fee:</b> \$621.65 <b>Benefit:</b> 75% = \$466.25	
	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.)	
30306	(See para TN.8.137, TN.8.138 of explanatory notes to this Category) <b>Fee:</b> \$811.45 <b>Benefit:</b> 75% = \$608.60	
	Partial or subtotal thyroidectomy (Anaes.) (Assist.)	
30310	(See para TN.8.137 of explanatory notes to this Category) <b>Fee:</b> \$811.45 <b>Benefit:</b> 75% = \$608.60	
	THYROGLOSSAL CYST or FISTULA or both, on a person 10 years of age or over. Radic of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.)	al removal
30314	<b>Fee:</b> \$464.70 <b>Benefit:</b> 75% = \$348.55	
	Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adenoma through cervical incision for an image localised adenoma, including thymectomy.	a small
	For any particular patient - applicable only once per occasion on which the service is provid	ed.
	Not in association with a service to which item 30318, 30317 or 30320 applies. (Anaes.) (As	ssist.)
30315	<b>Fee:</b> \$1,158.15 <b>Benefit:</b> 75% = \$868.65	
	Redo parathyroidectomy. Cervical re-exploration for persistent or recurrent hyperparathyroi including thymectomy and cervical exploration of the mediastinum.	dism,
	For any particular patient - applicable only once per occasion on which the service is provid	ed.
	Not in association with a service to which item 30315, 30318 or 30320 applies. (Anaes.) (As	ssist.)
30317	<b>Fee:</b> \$1,386.75 <b>Benefit:</b> 75% = \$1040.10	
	Open parathyroidectomy, exploration and removal of 1 or more adenoma or hyperplastic glacervical incision including thymectomy and cervical exploration of the mediastinum when p	
	For any particular patient - applicable only once per occasion on which the service is provid	ed.
	Not in association with a service to which item 30315, 30317 or 30320 applies. (Anaes.) (As	ssist.)
30318	<b>Fee:</b> \$1,158.15 <b>Benefit:</b> 75% = \$868.65	
	Removal of a mediastinal parathyroid adenoma via sternotomy or mediastinal thorascopic a	oproach.
	For any particular patient - applicable only once per occasion on which the service is provid	ed.
	Not in association with a service to which item 30315, 30317 or 30318 applies. (Anaes.) (As	ssist.)
30320	<b>Fee:</b> \$1,386.75 <b>Benefit:</b> 75% = \$1040.10	
	Excision of phaeochromocytoma or extraadrenal paraganglioma via endoscopic or open app (Anaes.) (Assist.)	roach.
30323	<b>Fee:</b> \$1,386.75 <b>Benefit:</b> 75% = \$1040.10	
	Excision of an adrenocortical tumour or hyperplasia via endoscopic or open approach. (Anac	es.) (Assist.)
30324	<b>Fee:</b> \$1,386.75 <b>Benefit:</b> 75% = \$1040.10	
30326	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal	duct and

T8. SUF	RGICAL OPERAT	ONS 1. GENERAL
	portion of hyoid	bone, on a person under 10 years of age (Anaes.) (Assist.)
	<b>Fee:</b> \$604.10	<b>Benefit:</b> 75% = \$453.10
	LYMPH NODE	of GROIN, limited excision of (Anaes.)
30329	Fee: \$250.90	<b>Benefit:</b> 75% = \$188.20 85% = \$213.30
	LYMPH NODE	of GROIN, radical excision of (Anaes.) (Assist.)
30330	Fee: \$730.25	<b>Benefit:</b> 75% = \$547.70
	LYMPH NODE	of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)
30332	Fee: \$352.30	<b>Benefit:</b> 75% = \$264.25
	LYMPH NODE	S of AXILLA, complete excision of, to level I (Anaes.) (Assist.)
	-	of explanatory notes to this Category)
30335	Fee: \$880.70	Benefit: 75% = \$660.55
		S of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.)
30336	(See para TN.8.13 <b>Fee:</b> \$1.056.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$792.70
	,	(exploratory), including associated biopsies, where no other intra-abdominal procedure
	is performed (Ar	aes.) (Assist.)
30373	Fee: \$491.00	<b>Benefit:</b> 75% = \$368.25
	Gastrotomy, on a diverticulum, Su	erostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, person 10 years of age or over. Reduction of intussusception, Removal of Meckel's cure of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, alt) or Drainage of pancreas (Anaes.) (Assist.)
30375	(See para TN.8.14 <b>Fee:</b> \$529.60	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$397.20
		INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other rocedure is performed) on a person 10 years of age or over (Anaes.) (Assist.)
30376	Fee: \$529.60	<b>Benefit:</b> 75% = \$397.20
		involving division of adhesions in conjunction with another intraabdominal procedure ken to divide the adhesions is between 45 minutes and 2 hours, on a person 10 years of es.) (Assist.)
30378	<b>Fee:</b> \$532.10	<b>Benefit:</b> 75% = \$399.10
		WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) assertion of long intestinal tube (Anaes.) (Assist.)
30379	Fee: \$943.00	<b>Benefit:</b> 75% = \$707.25
	ENTEROCUTA bowel (Anaes.) (	NEOUS FISTULA, radical repair of, involving extensive dissection and resection of Assist.)
30382	Fee: \$1,327.80	<b>Benefit:</b> 75% = \$995.85
30384		FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph d oophoropexy (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ons	1. GENERAL	
	Fee: \$1,117.00	<b>Benefit:</b> 75% = \$837.75		
		FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where ormed (Anaes.) (Assist.)	e no other	
30385	<b>Fee:</b> \$572.30	<b>Benefit:</b> 75% = \$429.25		
		INVOLVING OPERATION ON ABDOMINAL VISCERA (including to which another item in this Group applies (Anaes.) (Assist.)	ng pelvic viscera),	
30387	<b>Fee:</b> \$645.15	<b>Benefit:</b> 75% = \$483.90		
	LAPAROTOMY	for trauma involving 3 or more organs (Anaes.) (Assist.)		
30388	<b>Fee:</b> \$1,623.10	<b>Benefit:</b> 75% = \$1217.35		
		f age or over (Anaes.)	oic procedure, on a	
30390	(See para TN.8.15 o <b>Fee:</b> \$223.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$167.60		
	LAPAROSCOPY	with biopsy (Anaes.) (Assist.)		
30391	Fee: \$288.90	<b>Benefit:</b> 75% = \$216.70		
		EBULKING OPERATION for advanced intra-abdominal malignanc an independent procedure (Anaes.) (Assist.)	y, with or without	
30392	Fee: \$685.30	<b>Benefit:</b> 75% = \$514.00		
		C DIVISION OF ADHESIONS in association with another intra-abde ken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)	ominal procedure	
30393	Fee: \$532.10	<b>Benefit:</b> 75% = \$399.10		
		for drainage of subphrenic abscess, pelvic abscess, appendiceal absceritonitis from any cause, with or without appendicectomy (Anaes.) (		
30394	Fee: \$500.75	<b>Benefit:</b> 75% = \$375.60		
	removal of foreig	for gross intra peritoneal sepsis requiring debridement of fibrin, with n material or enteric contents, with lavage of the entire peritoneal caven, with or without closure of abdomen and with or without mesh or z	rity via a major	
30396	(See para TN.8.16 o <b>Fee:</b> \$1,032.80	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$774.60		
		Y, via wound previously made and left open or closed with zipper, in s, and with or without drainage of loculated collections (Anaes.)	volving change of	
30397	Fee: \$236.05	<b>Benefit:</b> 75% = \$177.05		
		Y, final closure of wound made at previous operation, after removal or all of mesh or zipper if previously inserted (Anaes.) (Assist.)	of dressings or	
30399	<b>Fee:</b> \$324.70	<b>Benefit:</b> 75% = \$243.55		
		WITH INSERTION OF PORTACATH for administration of cytotoxent of reservoir (Anaes.) (Assist.)	xic therapy	
30400	Fee: \$642.60	<b>Benefit:</b> 75% = \$481.95		

T8. SUF	RGICAL OPERATI	ONS 1. GENERAL
	RETROPERITO	NEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.)
30402	Fee: \$472.05	<b>Benefit:</b> 75% = \$354.05
	VENTRAL, INC without mesh (Ar	ISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or naes.) (Assist.)
30403	Fee: \$529.60	<b>Benefit:</b> 75% = \$397.20
		NCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.)
30405	Fee: \$929.60	<b>Benefit:</b> 75% = \$697.20
	PARACENTESI	S ABDOMINIS (Anaes.)
30406	Fee: \$53.05	<b>Benefit:</b> 75% = \$39.80 85% = \$45.10
	PERITONEOVE	NOUS shunt, insertion of (Anaes.) (Assist.)
30408	Fee: \$398.35	<b>Benefit:</b> 75% = \$298.80
	LIVER BIOPSY	percutaneous (Anaes.)
30409	Fee: \$177.25	<b>Benefit:</b> 75% = \$132.95 85% = \$150.70
	LIVER BIOPSY procedure (Anaes	by wedge excision when performed in conjunction with another intraabdominal s.)
30411	Fee: \$90.20	<b>Benefit:</b> 75% = \$67.65
	LIVER BIOPSY (Anaes.)	by core needle, when performed in conjunction with another intra-abdominal procedure
30412	Fee: \$53.20	<b>Benefit:</b> 75% = \$39.90 85% = \$45.25
	LIVER, subsegm	ental resection of, (local excision), other than for trauma (Anaes.) (Assist.)
30414	Fee: \$700.85	<b>Benefit:</b> 75% = \$525.65
	LIVER, segment	al resection of, other than for trauma (Anaes.) (Assist.)
30415	Fee: \$1,401.55	<b>Benefit:</b> 75% = \$1051.20
	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.)	
30416	Fee: \$760.95	<b>Benefit:</b> 75% = \$570.75
	LIVER CYSTS, diameter (Anaes.	laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in (Assist.)
30417	Fee: \$1,141.35	<b>Benefit:</b> 75% = \$856.05
	LIVER, lobecton	ny of, other than for trauma (Anaes.) (Assist.)
30418	Fee: \$1,623.10	<b>Benefit:</b> 75% = \$1217.35
	LIVER TUMOU	RS, destruction of, by hepatic cryotherapy, not being a service associated with a service 950 or 50952 applies (Anaes.) (Assist.)
30419	Fee: \$830.15	<b>Benefit:</b> 75% = \$622.65 85% = \$745.45
30421	LIVER, TRI-SEC	GMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.)

	ONS 1. GENERAL		
(Assist.)			
Fee: \$2,028.50	<b>Benefit:</b> 75% = \$1521.40		
LIVER, repair of	superficial laceration of, for trauma (Anaes.) (Assist.)		
Fee: \$686.15	<b>Benefit:</b> 75% = \$514.65		
LIVER, repair of	deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)		
Fee: \$1,327.80	<b>Benefit:</b> 75% = \$995.85		
LIVER, segmenta	l resection of, for trauma (Anaes.) (Assist.)		
Fee: \$1,585.95	<b>Benefit:</b> 75% = \$1189.50		
LIVER, lobectom	y of, for trauma (Anaes.) (Assist.)		
<b>Fee:</b> \$1,696.70	<b>Benefit:</b> 75% = \$1272.55 85% = \$1612.00		
LIVER, extended	lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)		
Fee: \$2,360.45	<b>Benefit:</b> 75% = \$1770.35 85% = \$2275.75		
LIVER ABSCESS	S, open abdominal drainage of (Anaes.) (Assist.)		
Fee: \$529.60	<b>Benefit:</b> 75% = \$397.20 85% = \$450.20		
LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.)			
<b>Fee:</b> \$737.65	<b>Benefit:</b> 75% = \$553.25		
	OF LIVER, peritoneum or viscus, complete removal of contents of, with or without adicles (Anaes.) (Assist.)		
Fee: \$597.55	<b>Benefit:</b> 75% = \$448.20		
	OF LIVER, peritoneum or viscus, complete removal of contents of, with or without adicles, with omentoplasty or myeloplasty (Anaes.) (Assist.)		
<b>Fee:</b> \$663.90	<b>Benefit:</b> 75% = \$497.95		
HYDATID CYST (Anaes.) (Assist.)	OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall)		
Fee: \$826.30	<b>Benefit:</b> 75% = \$619.75		
HYDATID CYST	OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)		
Fee: \$1,169.25	<b>Benefit:</b> 75% = \$876.95 85% = \$1084.55		
OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed durin the 1 operation) (Anaes.) (Assist.)			
Fee: \$188.55	<b>Benefit:</b> 75% = \$141.45		
interventional ima	AM, percutaneous transhepatic, and insertion of biliary drainage tube, using a leging techniques - but not including imaging, not being a service associated with a tem 30451 applies (Anaes.) (Assist.)		
Fee: \$534.80	<b>Benefit:</b> 75% = \$401.10 85% = \$454.60		
	Fee: \$2,028.50  LIVER, repair of some see: \$686.15  LIVER, repair of some see: \$1,327.80  LIVER, segmentan see: \$1,585.95  LIVER, lobectom see: \$1,696.70  LIVER, extended see: \$2,360.45  LIVER ABSCESS see: \$529.60  LIVER ABSCESS see: \$529.60  LIVER ABSCESS see: \$737.65  HYDATID CYST suture of biliary rates see: \$597.55  HYDATID CYST suture of biliary rates see: \$663.90  HYDATID CYST suture of biliary rates see: \$663.90  HYDATID CYST (Anaes.) (Assist.)  Fee: \$826.30  HYDATID CYST (Anaes.) (Assist.)  Fee: \$1,169.25  OPERATIVE CHOPERATIVE ULT the 1 operation) (Assist.)  Fee: \$188.55  CHOLANGIOGR interventional imagerize to which its service to which its service to which its service service sees sees sees service service service service service service service to which its service se		

T8. SUF	RGICAL OPERAT	ONS 1. GENERAL	
	INTRA OPERA	TVE ULTRASOUND for staging of intra abdominal tumours (Anaes.)	
30441	Fee: \$138.45	<b>Benefit:</b> 75% = \$103.85	
	CHOLEDOCHO	SCOPY in conjunction with another procedure (Anaes.)	
30442	Fee: \$188.55	<b>Benefit:</b> 75% = \$141.45	
	CHOLECYSTE	TOMY (Anaes.) (Assist.)	
30443	Fee: \$751.20	<b>Benefit:</b> 75% = \$563.40	
	LAPAROSCOPI	C CHOLECYSTECTOMY (Anaes.) (Assist.)	
30445	Fee: \$751.20	<b>Benefit:</b> 75% = \$563.40	
	LAPAROSCOPI (Assist.)	C CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.)	
30446	Fee: \$751.20	<b>Benefit:</b> 75% = \$563.40	
	LAPAROSCOPI duct (Anaes.) (A	C CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic sist.)	
30448	Fee: \$988.45	<b>Benefit:</b> 75% = \$741.35	
		C CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic (Anaes.) (Assist.)	
30449	Fee: \$1,099.15	<b>Benefit:</b> 75% = \$824.40	
		BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques ice associated with a service to which items 36627, 36630, 36645 or 36648 applies	
30450	Fee: \$532.80	<b>Benefit:</b> 75% = \$399.60 85% = \$452.90	
		NAGE TUBE, exchange of, using interventional imaging techniques - but not including g a service associated with a service to which item 30440 applies (Anaes.) (Assist.)	
30451	<b>Fee:</b> \$271.95	<b>Benefit:</b> 75% = \$204.00 85% = \$231.20	
	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.)		
30452	Fee: \$383.55	<b>Benefit:</b> 75% = \$287.70	
	CHOLEDOCHO (Assist.)	ΓΟΜΥ (with or without cholecystectomy), with or without removal of calculi (Anaes.)	
30454	<b>Fee:</b> \$876.30	<b>Benefit:</b> 75% = \$657.25	
	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.)		
30455	Fee: \$1,030.25	<b>Benefit:</b> 75% = \$772.70	
	CHOLEDOCHO (Assist.)	TOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.)	
30457	Fee: \$1,401.55	<b>Benefit:</b> 75% = \$1051.20 85% = \$1316.85	
	TRANSDUODE	NAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of	

T8. SUF	RGICAL OPERATION	ONS 1. GENERA	
	sphincteroplasty of (Anaes.) (Assist.)	of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy	
	Fee: \$1,030.25	<b>Benefit:</b> 75% = \$772.70	
		PUODENOSTOMY, CHOLECYSTOENTEROSTOMY, EJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery .) (Assist.)	
30460	<b>Fee:</b> \$876.30	<b>Benefit:</b> 75% = \$657.25	
		CTION of porta hepatis with biliary-enteric anastomoses, not being a service service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.)	
30461	Fee: \$1,502.05	<b>Benefit:</b> 75% = \$1126.55	
	RADICAL RESE anastomoses (Ana	CTION of common hepatic duct and right and left hepatic ducts, with 2 duct es.) (Assist.)	
30463	Fee: \$1,844.25	<b>Benefit:</b> 75% = \$1383.20	
		CTION of common hepatic duct and right and left hepatic ducts, involving more than resection of segment or major portion of segment of liver (Anaes.) (Assist.)	
30464	Fee: \$2,213.10	<b>Benefit:</b> 75% = \$1659.85	
	INTRAHEPATIC system (Anaes.) (	biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal Assist.)	
30466	Fee: \$1,276.15	<b>Benefit:</b> 75% = \$957.15	
	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.)		
30467	Fee: \$1,578.55	<b>Benefit:</b> 75% = \$1183.95	
	BILIARY STRIC	TURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.)	
30469	Fee: \$1,748.45	<b>Benefit:</b> 75% = \$1311.35 85% = \$1663.75	
		DMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or f bile duct or ducts (Anaes.) (Assist.)	
30472	Fee: \$944.20	<b>Benefit:</b> 75% = \$708.15 85% = \$859.50	
	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 30478 or 30479 applies. (Anaes.)		
30473	(See para TN.8.17 o <b>Fee:</b> \$179.95	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$135.00 85% = \$153.00	
	Endoscopic dilatation of stricture of upper gastrointestinal tract (including the use of imaging intensification where clinically indicated) (Anaes.)		
30475	(See para TN.8.17, <b>Fee:</b> \$354.55	TN.8.133 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$265.95  85% = \$301.40	
30478		(other than a service to which item 41816, 41822 or 41825 applies), gastroscopy, nendoscopy or push enteroscopy, one or more such procedures, if:	

## **T8. SURGICAL OPERATIONS** 1. GENERAL (a) the procedures are performed using one or more of the following endoscopic procedures: (i) polypectomy; (ii) sclerosing or adrenalin injections; (iii) banding; (iv) endoscopic clips; (v) haemostatic powders; (vi) diathermy; (vii) argon plasma coagulation; and (b) the procedures are for the treatment of one or more of the following: (i) upper gastrointestinal tract bleeding; (ii) polyps; (iii) removal of foreign body; (iv) oesophageal or gastric varices; (v) peptic ulcers; (vi) neoplasia; (vii) benign vascular lesions; (viii) strictures of the gastrointestinal tract; (ix) tumorous overgrowth through or over oesophageal stents; other than a service associated with a service to which item 30473 or 30479 applies (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Benefit:** 75% = \$187.15 85% = \$212.10 Endoscopy with laser therapy, for the treatment of one or more of the following: (a) neoplasia; (b) benign vascular lesions; (c) strictures of the gastrointestinal tract; (d) tumorous overgrowth through or over oesophageal stents; (e) peptic ulcers; 30479

T8. SUF	GICAL OPERATIONS 1. GENERAL
	(f) angiodysplasia;
	(g) gastric antral vascular ectasia;
	(h) post-polypectomy bleeding;
	other than a service associated with a service to which item 30473 or 30478 applies (Anaes.)
	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$483.70 <b>Benefit:</b> 75% = \$362.80 85% = \$411.15
	PERCUTANEOUS GASTROSTOMY (initial procedure):
	(a) including any associated imaging services; and
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)
30481	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$362.70 <b>Benefit:</b> 75% = \$272.05 85% = \$308.30
	PERCUTANEOUS GASTROSTOMY (repeat procedure):
	(a) including any associated imaging services; and
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)
30482	<b>Fee:</b> \$257.90 <b>Benefit:</b> 75% = \$193.45 85% = \$219.25
	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CHAIT etc.) or STOMAL INDWELLING DEVICE:
	(a) non-endoscopic insertion of; or
	(b) non-endoscopic replacement of;
	on a person 10 years of age or over, excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)
30483	<b>Fee:</b> \$179.90 <b>Benefit:</b> 75% = \$134.95 85% = \$152.95
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.)
30484	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$370.75 <b>Benefit:</b> 75% = \$278.10 85% = \$315.15
	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.)
30485	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$572.30 <b>Benefit:</b> 75% = \$429.25 85% = \$487.60
	SMALL BOWEL INTUBATION as an independent procedure (Anaes.)
30488	<b>Fee:</b> \$91.45 <b>Benefit:</b> 75% = \$68.60 85% = \$77.75
	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.)
30490	(See para TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$534.80 <b>Benefit:</b> 75% = \$401.10 85% = \$454.60

T8. SUF	RGICAL OPERATIO	ons 1	. GENERAL	
	BILE DUCT, END	OOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes	s.)	
30491	(See para TN.8.17 of <b>Fee:</b> \$564.25	explanatory notes to this Category) <b>Benefit:</b> 75% = \$423.20		
		CUTANEOUS STENTING OF (including dilatation when performed), uging techniques - but not including imaging (Anaes.)	ısing	
30492	Fee: \$799.90	<b>Benefit:</b> 75% = \$599.95		
	ENDOSCOPIC BI	LIARY DILATATION (Anaes.)		
30494	(See para TN.8.17 of <b>Fee:</b> \$427.25	Explanatory notes to this Category) <b>Benefit:</b> 75% = \$320.45		
		S BILIARY DILATATION for biliary stricture, using interventional image including imaging (Anaes.)	ging	
30495	Fee: \$799.90	<b>Benefit:</b> 75% = \$599.95		
	VAGOTOMY, tru	ncal or selective, with or without pyloroplasty or gastroenterostomy (Ana	aes.) (Assist.)	
30496	Fee: \$597.55	<b>Benefit:</b> 75% = \$448.20 85% = \$512.85		
	VAGOTOMY and	ANTRECTOMY (Anaes.) (Assist.)		
30497	<b>Fee:</b> \$712.50	<b>Benefit:</b> 75% = \$534.40		
	· ·	VAGOTOMY, highly selective (Anaes.) (Assist.)		
30499	<b>Fee:</b> \$847.40	<b>Benefit:</b> 75% = \$635.55		
		thly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.)		
30500	<b>Fee:</b> \$907.40	<b>Benefit:</b> 75% = \$680.55 85% = \$822.70		
	·	thly selective, with dilatation of pylorus (Anaes.) (Assist.)		
30502	Fee: \$1,001.45	<b>Benefit:</b> 75% = \$751.10		
30302	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.)		or peptic	
30503	Fee: \$1.121.45	<b>Benefit:</b> 75% = \$841.10 85% = \$1036.75		
		TIC ULCER, control of, involving suture of bleeding point or wedge exci	sion (Anaes.)	
30505	<b>Fee:</b> \$560.70	<b>Benefit:</b> 75% = \$420.55		
	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.)		sion, and	
30506	Fee: \$981.20	<b>Benefit:</b> 75% = \$735.90		
		TC ULCER, control of, involving suture of bleeding point or wedge excigotomy (Anaes.) (Assist.)	sion, and	
30508	Fee: \$1,032.80	<b>Benefit:</b> 75% = \$774.60		
	BLEEDING PEPT (Anaes.) (Assist.)	TC ULCER, control of, involving gastric resection (other than wedge res	ection)	
30509	Fee: \$1,032.80	<b>Benefit:</b> 75% = \$774.60 85% = \$948.10		

T8. SUF	RGICAL OPERATION	ons	1. GENERAL
		y (including gastroduodenostomy) or enterocolostomy or enteroent any of items 31569 to 31581 apply (Anaes.) (Assist.)	terostomy, not being
30515	Fee: \$715.60	<b>Benefit:</b> 75% = \$536.70	
	GASTROENTER (Anaes.) (Assist.)	COSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY,	reconstruction of
30517	Fee: \$936.95	<b>Benefit:</b> 75% = \$702.75	
	Partial gastrectom apply (Anaes.) (A	ny, not being a service associated with a service to which any of ite assist.)	ms 31569 to 31581
30518	Fee: \$1,003.30	<b>Benefit:</b> 75% = \$752.50	
	GASTRIC TUMO (Anaes.) (Assist.)	DUR, removal of, by local excision, not being a service to which ite	em 30518 applies
30520	Fee: \$686.15	<b>Benefit:</b> 75% = \$514.65	
	GASTRECTOMY	Y, TOTAL, for benign disease (Anaes.) (Assist.)	
30521	Fee: \$1,468.00	<b>Benefit:</b> 75% = \$1101.00	
	GASTRECTOMY (Anaes.) (Assist.)	Y, SUBTOTAL RADICAL, for carcinoma, (including splenectomy	when performed)
30523	(See para TN.8.18 o <b>Fee:</b> \$1,534.25	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$1150.70	
		Y, TOTAL RADICAL, for carcinoma (including extended node disnd splenectomy when performed) (Anaes.) (Assist.)	ssection and distal
30524	Fee: \$1,689.25	<b>Benefit:</b> 75% = \$1266.95	
		Y, TOTAL, and including lower oesophagus, performed by left tho ag of diaphragmatic hiatus, (including splenectomy when performed	
30526	Fee: \$2,190.85	<b>Benefit:</b> 75% = \$1643.15	
		PERATION by fundoplasty, via abdominal or thoracic approach, phragmatic hiatus not being a service to which item 30601 applies	
30527	(See para TN.8.19 c <b>Fee:</b> \$885.25	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$663.95	
	ANTIREFLUX o (Anaes.) (Assist.)	peration by fundoplasty, with OESOPHAGOPLASTY for stricture	or short oesophagus
30529	(See para TN.8.19 o <b>Fee:</b> \$1,327.80	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$995.85	
	ANTIREFLUX o	peration by cardiopexy, with or without fundoplasty (Anaes.) (Assi	ist.)
30530	(See para TN.8.19 o <b>Fee:</b> \$796.75	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$597.60	
		ASTRIC MYOTOMY (Heller's operation) via abdominal or thoraction in the diaphragmatic hiatus, by laparoscopy or open operation (Anaethe	
30532	(See para TN.8.19 o <b>Fee:</b> \$914.85	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$686.15	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
		operation) via abdominal or thoracic approach, WITH diaphragmatic hiatus, by laparoscopy or open operation
30533	(See para TN.8.19 of explanatory notes to this Categor <b>Fee:</b> \$1,088.15 <b>Benefit:</b> 75% = \$816.15	y)
	OESOPHAGECTOMY with gastric reconstruction (Anaes.) (Assist.)	on by abdominal mobilisation and thoracotomy
30535	<b>Fee:</b> \$1,723.80 <b>Benefit:</b> 75% = \$1292.85	
	OESOPHAGECTOMY involving gastric reconst anastomosis in the neck or chest - 1 surgeon (Ana	ruction by abdominal mobilisation, thoracotomy and nes.) (Assist.)
30536	<b>Fee:</b> \$1,748.45 <b>Benefit:</b> 75% = \$1311.35	
		ruction by abdominal mobilisation, thoracotomy and y, principal surgeon (including aftercare) (Anaes.)
30538	<b>Fee:</b> \$1,209.85 <b>Benefit:</b> 75% = \$907.40	
	OESOPHAGECTOMY involving gastric reconst anastomosis in the neck or chest - conjoint surger	ruction by abdominal mobilisation, thoracotomy and ry, co-surgeon (Assist.)
30539	<b>Fee:</b> \$885.25 <b>Benefit:</b> 75% = \$663.95	
	OESOPHAGECTOMY, by trans-hiatal oesophag anastomosis) with posterior or anterior mediastin	
30541	<b>Fee:</b> \$1,541.80 <b>Benefit:</b> 75% = \$1156.35	
	OESOPHAGECTOMY, by trans-hiatal oesophag anastomosis) with posterior or anterior mediastin (including aftercare) (Anaes.) (Assist.)	gectomy (cervical and abdominal mobilisation, al placement - conjoint surgery, principal surgeon
30542	<b>Fee:</b> \$1,047.60 <b>Benefit:</b> 75% = \$785.70	
	OESOPHAGECTOMY, by trans-hiatal oesophag anastomosis) with posterior or anterior mediastin	gectomy (cervical and abdominal mobilisation, al placement - conjoint surgery, co-surgeon (Assist.)
30544	<b>Fee:</b> \$767.30 <b>Benefit:</b> 75% = \$575.50	
	OESOPHAGECTOMY with colon or jejunal ana thoracic anastomosis) - 1 surgeon (Anaes.) (Assis	stomosis, (abdominal and thoracic mobilisation with st.)
30545	<b>Fee:</b> \$1,866.50 <b>Benefit:</b> 75% = \$1399.90	
	OESOPHAGECTOMY with colon or jejunal ana thoracic anastomosis) - conjoint surgery, principa	stomosis, (abdominal and thoracic mobilisation with al surgeon (including aftercare) (Anaes.) (Assist.)
30547	<b>Fee:</b> \$1,283.55 <b>Benefit:</b> 75% = \$962.70 859	% = \$1198.85
		stomosis, (abdominal and thoracic mobilisation with
	thoracic anastomosis) - conjoint surgery, co-surg	eon (Assist.)
30548	<b>Fee:</b> \$958.90 <b>Benefit:</b> 75% = \$719.20 859	· · · · · · · · · · · · · · · · · · ·
30550	OESOPHAGECTOMY with colon or jejunal rep anastomosis of pedicle in the neck) - 1 surgeon (A	lacement (abdominal and thoracic mobilisation with Anaes.) (Assist.)

T8. SUF	RGICAL OPERATI	ONS 1. GENERAL
	Fee: \$2,095.20	<b>Benefit:</b> 75% = \$1571.40
		TOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with edicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.)
30551	<b>Fee:</b> \$1,445.90	<b>Benefit:</b> 75% = \$1084.45
		TOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with edicle in the neck) - conjoint surgery, co-surgeon (Assist.)
30553	<b>Fee:</b> \$1,069.50	<b>Benefit:</b> 75% = \$802.15 85% = \$984.80
	OESOPHAGECT	TOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.)
30554	<b>Fee:</b> \$2,331.15	<b>Benefit:</b> 75% = \$1748.40
		COMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon are) (Anaes.) (Assist.)
30556	Fee: \$1,608.10	<b>Benefit:</b> 75% = \$1206.10
	OESOPHAGECT	TOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.)
30557	Fee: \$1,187.70	<b>Benefit:</b> 75% = \$890.80
	OESOPHAGUS,	local excision for tumour of (Anaes.) (Assist.)
30559	Fee: \$863.15	<b>Benefit:</b> 75% = \$647.40 85% = \$778.45
	OESOPHAGEAI	PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)
30560	Fee: \$958.90	<b>Benefit:</b> 75% = \$719.20
		Y or COLOSTOMY, closure of (not involving resection of bowel), on a person 10 ver (Anaes.) (Assist.)
30562	Fee: \$604.50	<b>Benefit:</b> 75% = \$453.40
	COLOSTOMY C (Assist.)	OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes.)
30563	Fee: \$604.50	<b>Benefit:</b> 75% = \$453.40 85% = \$519.80
	SMALL BOWEL	STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.)
30564	Fee: \$784.65	<b>Benefit:</b> 75% = \$588.50
	SMALL INTEST (Assist.)	TNE, resection of, without anastomosis (including formation of stoma) (Anaes.)
30565	Fee: \$885.25	<b>Benefit:</b> 75% = \$663.95
	SMALL INTEST (Assist.)	TNE, resection of, with anastomosis, on a person 10 years of age or over (Anaes.)
30566	Fee: \$983.35	<b>Benefit:</b> 75% = \$737.55
	INTRAOPERAT (Assist.)	IVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.)
30568	Fee: \$737.65	<b>Benefit:</b> 75% = \$553.25
30569	ENDOSCOPIC E	EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy,

RGICAL OPERATI	ONS 1. GENERAL
with or without b	iopsies (Anaes.) (Assist.)
<b>Fee:</b> \$376.10	<b>Benefit:</b> 75% = \$282.10
APPENDICECTO over (Anaes.) (As	OMY, not being a service to which item 30574 applies on a person 10 years of age or ssist.)
Fee: \$452.55	<b>Benefit:</b> 75% = \$339.45
LAPAROSCOPI	C APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)
Fee: \$452.55	<b>Benefit:</b> 75% = \$339.45
NOTE: Multiple	Operation and Multiple Anaesthetic rules apply to this item
	OMY, when performed in conjunction with any other intraabdominal procedure incision (Anaes.)
Fee: \$125.20	<b>Benefit:</b> 75% = \$93.90
PANCREATIC A dissection (Anaes	ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic s.) (Assist.)
Fee: \$520.90	<b>Benefit:</b> 75% = \$390.70
	NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)
Fee: \$1,106.60	<b>Benefit:</b> 75% = \$829.95
	UMOUR, exploration of pancreas or duodenum, followed by local excision of r (Anaes.) (Assist.)
Fee: \$1,165.55	<b>Benefit:</b> 75% = \$874.20
ENDOCRINE TO tumour (Anaes.)	UMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal (Assist.)
Fee: \$1,062.15	<b>Benefit:</b> 75% = \$796.65
ENDOCRINE TU (Assist.)	UMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.)
Fee: \$774.55	<b>Benefit:</b> 75% = \$580.95
DISTAL PANCE	REATECTOMY (Anaes.) (Assist.)
Fee: \$1,213.35	<b>Benefit:</b> 75% = \$910.05
PANCREATICO pylorus (Anaes.)	D-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of (Assist.)
<b>Fee:</b> \$1,790.95	<b>Benefit:</b> 75% = \$1343.25
PANCREATIC (means (Anaes.) (	CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic Assist.)
Fee: \$712.50	<b>Benefit:</b> 75% = \$534.40
PANCREATIC O	CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)
1	
	Fee: \$376.10  APPENDICECTOVER (Anaes.) (ASSETS FEE: \$452.55  LAPAROSCOPIE Fee: \$452.55  NOTE: Multiple APPENDICECTOTE (APPENDICECTOTE (APPENDI

T8. SUF	RGICAL OPERATION	ONS 1. GENERAL
	PANCREATICO-	-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)
30589	<b>Fee:</b> \$1,271.10	<b>Benefit:</b> 75% = \$953.35
	PANCREATICO-	-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)
30590	<b>Fee:</b> \$1,401.55	<b>Benefit:</b> 75% = \$1051.20
	PANCREATECT	OMY, near total or total (including duodenum), with or without splenectomy (Anaes.)
	(Assist.)	
30593	Fee: \$1,917.95	<b>Benefit:</b> 75% = \$1438.50 85% = \$1833.25
		OMY for pancreatitis following previously attempted drainage procedure or partial
	resection (Anaes.)	(Assist.)
30594	<b>Fee:</b> \$2,213.10	<b>Benefit:</b> 75% = \$1659.85
	SPLENORRHAP	HY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)
30596	Fee: \$911.65	<b>Benefit:</b> 75% = \$683.75
	SPLENECTOMY	(Anaes.) (Assist.)
30597	<b>Fee:</b> \$731.70	<b>Benefit:</b> 75% = \$548.80
	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdorincision (Anaes.) (Assist.)	
30599	<b>Fee:</b> \$1,327.80	<b>Benefit:</b> 75% = \$995.85
	DIAPHRAGMAT	TIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)
30600	Fee: \$789.55	<b>Benefit:</b> 75% = \$592.20
		rnia, congential repair of, by thoracic or abdominal approach, not being a service to as 31569 to 31581 apply, on a person 10 years of age or over (Anaes.) (Assist.)
30601	Fee: \$972.60	<b>Benefit:</b> 75% = \$729.45
	PORTAL HYPER	RTENSION, porto-caval shunt for (Anaes.) (Assist.)
30602	Fee: \$1,578.55	<b>Benefit:</b> 75% = \$1183.95
		RTENSION, meso-caval shunt for (Anaes.) (Assist.)
30603	<b>Fee:</b> \$1,667.15	<b>Benefit:</b> 75% = \$1250.40 85% = \$1582.45
30003	- '	RTENSION, selective spleno-renal shunt for (Anaes.) (Assist.)
20.605		
30605	Fee: \$1,895.80	Benefit: 75% = \$1421.85
		RTENSION, oesophageal transection via stapler or oversew of gastric varices with or urisation (Anaes.) (Assist.)
30606	Fee: \$1,128.55	<b>Benefit:</b> 75% = \$846.45
	SMALL INTEST (Assist.)	INE, resection of, with anastomosis, on a person under 10 years of age (Anaes.)
30608	Fee: \$1,278.35	<b>Benefit:</b> 75% = \$958.80
30609		NGUINAL HERNIA, laparoscopic repair of, not being a service associated with a

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	service to which item 30614 applies (Anaes.) (Assist.)	
	<b>Fee:</b> \$471.95 <b>Benefit:</b> 75% = \$354.00	
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and covered by item 31345 and lipomata - removal of by surgical excision, where the sent for histological confirmation of diagnosis, on a person under 10 years of age, which another item in this Group applies (Anaes.) (Assist.)	specimen excised is
30611	<b>Fee:</b> \$572.35 <b>Benefit:</b> 75% = \$429.30 85% = \$487.65	
	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of which item 30403 or 30615 applies, on a person 10 years of age or over (Anaes.) (	
30614	<b>Fee:</b> \$471.95 <b>Benefit:</b> 75% = \$354.00	
	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, resection, on a person 10 years of age or over (Anaes.) (Assist.)	without bowel
30615	<b>Fee:</b> \$529.60 <b>Benefit:</b> 75% = \$397.20	
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels invotissue and lymph nodes from one side of the neck, on a person under 10 years of a	
30618	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$530.60 <b>Benefit:</b> 75% = \$397.95 85% = \$451.05	
	LAPAROSCOPIC SPLENECTOMY, on a person under 10 years of age (Anaes.)	(Assist.)
30619	<b>Fee:</b> \$951.25 <b>Benefit:</b> 75% = \$713.45	
	Repair of symptomatic umbilical, epigastric or linea alba hernia requiring mesh or in a person 10 years of age or over, other than a service to which item 30403 or 30 (Assist.)	
30621	<b>Fee:</b> \$414.00 <b>Benefit:</b> 75% = \$310.50	
	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Sut peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty pancreas on a person under 10 years of age (Anaes.) (Assist.)	ure of perforated
30622	(See para TN.8.14 of explanatory notes to this Category) <b>Fee:</b> \$688.50 <b>Benefit:</b> 75% = \$516.40	
	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (whintraabdominal procedure is performed) on a person under 10 years of age (Anaes.	
30623	<b>Fee:</b> \$688.50 <b>Benefit:</b> 75% = \$516.40	
	LAPAROTOMY involving division of adhesions in conjunction with another intra where the time taken to divide the adhesions is between 45 minutes and 2 hours, or years of age (Anaes.) (Assist.)	
30626	<b>Fee:</b> \$691.70 <b>Benefit:</b> 75% = \$518.80	
	LAPAROSCOPY, diagnostic, not being a service associated with any other laparo person under 10 years of age (Anaes.)	scopic procedure, on a
30627	(See para TN.8.15 of explanatory notes to this Category) <b>Fee:</b> \$290.55 <b>Benefit:</b> 75% = \$217.95	

T8. SUF	URGICAL OPERATIONS 1. GENERAL			
	HYDROCELE, tapping of			
30628	Fee: \$36.15	<b>Benefit:</b> 75% = \$27.15 85% = \$30.75		
	Hydrocele, removal of, other than a service associated with a service to which item 30641, 30642 or 30644 applies (Anaes.)			
30631	<b>Fee:</b> \$240.45	<b>Benefit:</b> 75% = \$180.35 85% = \$204.40		
		al correction of, other than a service associated with a service to which item 30641, plies—one procedure (Anaes.) (Assist.)		
30635	Fee: \$296.45	<b>Benefit:</b> 75% = \$222.35		
		BUTTON, caecostomy antegrade enema device (chait etc) and/or stomal indwelling copic insertion of, or non-endoscopic replacement of, on a person under 10 years of		
30636	Fee: \$236.90	<b>Benefit:</b> 75% = \$177.70 85% = \$201.40		
	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 years of age (Anaes.) (Assist.)			
30637	Fee: \$785.90	<b>Benefit:</b> 75% = \$589.45		
	COLOSTOMY OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.)			
30639	Fee: \$785.90	<b>Benefit:</b> 75% = \$589.45 85% = \$701.20		
	Repair of large and irreducible scrotal hernia, where duration of surgery exceeds 2 hours, years of age or over, other than a service to which item 30403, 30405, 30614, 30615 or 30 (Anaes.) (Assist.)			
30640	Fee: \$929.60	<b>Benefit:</b> 75% = \$697.20		
	ORCHIDECTOM (Anaes.) (Assist.)	Y, simple or subscapsular, unilateral with or without insertion of testicular prosthesis		
30641	Fee: \$414.00	<b>Benefit:</b> 75% = \$310.50		
	Orchidectomy, radical, unilateral, with or without insertion of testicular prosthesis, other than a service associated with a service to which item 30631, 30635, 30641, 30643 or 30644 applies (Anaes.) (Assist.)			
30642	Fee: \$529.60	<b>Benefit:</b> 75% = \$397.20		
	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis on a person under 10 years of age (Anaes.) (Assist			
30643	Fee: \$688.50	<b>Benefit:</b> 75% = \$516.40		
		OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and cision of spermatic cord and testis on a person 10 years of age or over (Anaes.)		
30644	Fee: \$529.60	<b>Benefit:</b> 75% = \$397.20		
	APPENDICECTO age (Anaes.) (Assi	MY, not being a service to which item 30574 applies, on a person under 10 years of st.)		
30645	Fee: \$588.25	<b>Benefit:</b> 75% = \$441.20		
30646	LAPAROSCOPIC	APPENDICECTOMY, on a person under 10 years of age (Anaes.) (Assist.)		
20040	1			

T8. SUF	RGICAL OPERATIONS 1. GENER		
	Fee: \$588.25	<b>Benefit:</b> 75% = \$441.20	
	HAEMORRHAC years of age (Ana	GE, arrest of, following circumcision requiring general anaesthesia on a person under 10 nes.)	
30649	Fee: \$190.65	<b>Benefit:</b> 75% = \$143.00 85% = \$162.10	
	Circumcision of	the penis (other than a service to which item 30658 applies)	
30654	Fee: \$47.25	<b>Benefit:</b> 75% = \$35.45 85% = \$40.20	
	Circumcision of or Group T10 app	the penis, when performed in conjunction with a service to which an item in Group T7 plies (Anaes.)	
30658	Fee: \$144.25	<b>Benefit:</b> 75% = \$108.20 85% = \$122.65	
	HAEMORRHAC of age or over (A	GE, arrest of, following circumcision requiring general anaesthesia on a person 10 years naes.)	
30663	Fee: \$146.65	<b>Benefit:</b> 75% = \$110.00 85% = \$124.70	
		S or PHIMOSIS, reduction of, under general anaesthesia, with or without dorsal g a service associated with a service to which another item in this Group applies	
30666	Fee: \$48.20	<b>Benefit:</b> 75% = \$36.15 85% = \$41.00	
	COCCYX, excis	ion of (Anaes.) (Assist.)	
30672	Fee: \$452.55	<b>Benefit:</b> 75% = \$339.45	
	PILONIDAL SIN	NUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.)	
30676	Fee: \$385.10	<b>Benefit:</b> 75% = \$288.85 85% = \$327.35	
	PILONIDAL SIN	NUS, injection of sclerosant fluid under anaesthesia (Anaes.)	
30679	<b>Fee:</b> \$97.85	<b>Benefit:</b> 75% = \$73.40 85% = \$83.20	
	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.)		
30680	(See para TN.8.17 <b>Fee:</b> \$1,188.70	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$891.55 85% = \$1104.00	
	WITHOUT intra	opy, examination of the small bowel (anal approach), with or without biopsy, procedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not the another item in this subgroup (with the exception of item 30680 or 30684)	
30682			
	1		

## **T8. SURGICAL OPERATIONS** 1. GENERAL 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 bleeding. the cause of (Anaes.) (See para TN.8.17 of explanatory notes to this Category) **Benefit:** 75% = \$891.55 85% = \$1104.00 Fee: \$1,188.70 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, laser coagulation or argon plasma 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: (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 TN.8.17 of explanatory notes to this Category) 30684 **Fee:** \$1,462.90 **Benefit:** 75% = \$1097.20 85% = \$1378.20 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, laser coagulation or argon plasma 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: (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 TN.8.17 of explanatory notes to this Category) 30686 Fee: \$1,462.90 **Benefit:** 75% = \$1097.20 85% = \$1378.20 ENDOSCOPY with RADIOFREQUENCY ABLATION of mucosal metaplasia for the treatment of 30687

T8. SUF	RGICAL OPERATIONS 1. GENERA
	Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.)
	(See para TN.8.17, TN.8.20 of explanatory notes to this Category) <b>Fee:</b> \$483.70 <b>Benefit:</b> 75% = \$362.80 85% = \$411.15
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30688	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$370.75 <b>Benefit:</b> 75% = \$278.10 85% = \$315.15
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30690	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$572.30 <b>Benefit:</b> 75% = \$429.25 85% = \$487.60
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30692	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$370.75 <b>Benefit:</b> 75% = \$278.10 85% = \$315.15
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30694	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$572.30 <b>Benefit:</b> 75% = \$429.25 85% = \$487.60
	ENDOSCOPIC ULTRASOUND GUIDED FINE NEEDLE ASPIRATION BIOPSY(S) (endoscopy with ultrasound imaging) to obtain one or more specimens from either:
	(a) mediastinal mass(es) or
	(b) locoregional nodes to stage non-small cell lung carcinoma
	not being a service associated with another item in this subgroup or to which items 30710 and 55054 apply (Anaes.)
30696	(See para TN.8.21 of explanatory notes to this Category) <b>Fee:</b> \$572.30 <b>Benefit:</b> 75% = \$429.25 85% = \$487.60
	ENDOBRONCHIAL ULTRASOUND GUIDED BIOPSY(S) (bronchoscopy with ultrasound imaging, with or without associated fluoroscopic imaging) to obtain one or more specimens by either:
30710	

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	(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 TN.8.21 of explanatory notes to this Category) <b>Fee:</b> \$572.30 <b>Benefit:</b> 75% = \$429.25 85% = \$487.60
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections (Anaes.)
31000	(See para TN.8.151 of explanatory notes to this Category) <b>Fee:</b> \$590.20 <b>Benefit:</b> 75% = \$442.65  85% = \$505.50
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive) (Anaes.)
31001	(See para TN.8.151 of explanatory notes to this Category) <b>Fee:</b> \$737.65 <b>Benefit:</b> 75% = \$553.25  85% = \$652.95
	Mohs surgery of skin tumour located on the head, neck, genitalia, hand, digits, leg (below knee) or foot, utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or more sections (Anaes.)
31002	(See para TN.8.151 of explanatory notes to this Category) <b>Fee:</b> \$885.25 <b>Benefit:</b> 75% = \$663.95  85% = \$800.55
	Mohs surgery 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, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—6 or fewer sections
	Not applicable to a service performed in association with a service to which item 31000 applies (Anaes.)
31003	(See para TN.8.151 of explanatory notes to this Category) <b>Fee:</b> \$590.20 <b>Benefit:</b> 75% = \$442.65 85% = \$505.50
	Mohs surgery 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, if the specialist is recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—7 to 12 sections (inclusive)
	Not applicable to a service performed in association with a service to which item 31001 applies (Anaes.)
31004	(See para TN.8.151 of explanatory notes to this Category) <b>Fee:</b> \$737.65 <b>Benefit:</b> 75% = \$553.25 85% = \$652.95

T8. SUF	RGICAL OPERATIONS 1. GENER	AL
	Mohs surgery of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, ar histological examination of all excised tissue by the specialist performing the procedure, if the specialist recognised by the Australasian College of Dermatologists as an approved Mohs surgeon—13 or mo sections	ist
	Not applicable to a service performed in association with a service to which item 31002 applies (Anae	es.)
31005	(See para TN.8.151 of explanatory notes to this Category) <b>Fee:</b> \$885.25 <b>Benefit:</b> 75% = \$663.95  85% = \$800.55	
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:	
	(a) the lesion size is not more than 10 mm in diameter; and	
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and	ıd
	(c) the specimen excised is sent for histological examination (Anaes.)	
31206	<b>Fee:</b> \$97.00 <b>Benefit:</b> 75% = \$72.75 85% = \$82.45	
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:	
	(a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and	
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and	ıd
	(c) the specimen excised is sent for histological examination (Anaes.)	
31211	<b>Fee:</b> \$125.05 <b>Benefit:</b> 75% = \$93.80 85% = \$106.30	
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:	
	(a) the lesion size is more than 20 mm in diameter; and	
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and	ıd
	(c) the specimen excised is sent for histological examination (Anaes.)	
31216	<b>Fee:</b> \$145.85 <b>Benefit:</b> 75% = \$109.40 85% = \$124.00	
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of 4 to 10 lesions and suture, if:	d
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other than by shave excision); and	Э
	(c) all of the specimens excised are sent for histological examination (Anaes.)	
31220	<b>Fee:</b> \$218.00 <b>Benefit:</b> 75% = \$163.50 85% = \$185.30	
31221	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at an operation) removal of 4 to 10 lesions, if:	ı),

T8. SUF	RGICAL OPERATIONS 1. GENE	ERAL
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from a mucous membrane by surgical excision (other than by shave excision	); and
	(c) each site of excision is closed by suture; and	
	(d) all of the specimens excised are sent for histological examination (Anaes.)	
	<b>Fee:</b> \$218.00 <b>Benefit:</b> 75% = \$163.50 85% = \$185.30	
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulcers or scars (other than scars removed during the surgical approach at an operation), removal of more than 10 lesions, if:	S
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by surgical excitother than by	ision
	shave excision); and	
	(c) each site of excision is closed by suture; and	
	(d) all of the specimens excised are sent for histological examination (Anaes.)	
31225	<b>Fee:</b> \$387.40 <b>Benefit:</b> 75% = \$290.55 85% = \$329.30	
	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.)	Έ
31245	(See para TN.8.23 of explanatory notes to this Category) <b>Fee:</b> \$374.90 <b>Benefit:</b> 75% = \$281.20 85% = \$318.70	
	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	where
31250	<b>Fee:</b> \$374.90 <b>Benefit:</b> 75% = \$281.20 85% = \$318.70	
	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if:	
	(a) the specimen excised is sent for histological confirmation; and	
	(b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31005, 31356 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31375 or 31376 excised (Anaes.)	
31340	<b>Derived Fee:</b> 75% of the fee for excision of malignant tumour	
	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and 50mm more in diameter, or is sub-fascial, where the specimen is sent for histological confirmation of diag (Anaes.)	
31345	<b>Fee:</b> \$214.35 <b>Benefit:</b> 75% = \$160.80 85% = \$182.20	
	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, upper arm or thigh fat because of repeated insulin injections, if:	per
31346	(a) the lesion is subcutaneous; and	

T8. SUI	RGICAL OPERATIONS 1. GENERAL
	(b) the lesion is 50 mm or more in diameter; and
	(c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.)
	(See para TN.8.101 of explanatory notes to this Category) <b>Fee:</b> \$214.35 <b>Benefit:</b> 75% = \$160.80  85% = \$182.20
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service to which another item in this Group applies (Anaes.) (Assist.)
31350	<b>Fee:</b> \$440.30 <b>Benefit:</b> 75% = \$330.25 85% = \$374.30
	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal of by surgical excision, where <i>histological proof of malignancy has been obtained</i> , not being a service to which another item in this Group applies (Anaes.) (Assist.)
31355	<b>Fee:</b> \$725.90 <b>Benefit:</b> 75% = \$544.45 85% = \$641.20
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and
	(b) the necessary excision diameter is less than 6 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
31356	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$224.90 <b>Benefit:</b> 75% = \$168.70  85% = \$191.20
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous area; and
	(b) the necessary excision diameter is less than 6 mm; and
	(c) the excised specimen is sent for histological examination;
	not in association with item 45201 (Anaes.)
31357	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$111.45 <b>Benefit:</b> 75% = \$83.60 85% = \$94.75
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
31358	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous

T8. SUR	GICAL OPERATIONS 1. GENE	RAL
	area; and	
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$275.20 <b>Benefit:</b> 75% = \$206.40 85% = \$233.95	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31375 or 31376), surgical excision (other than by shave excision), if:	374,
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia (the applicable site)	); and
	(b) the necessary excision area is at least one third of the surface area of the applicable site; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy	
	(H) (Anaes.)	
31359	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$335.45 <b>Benefit:</b> 75% = \$251.60	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation surgical excision (other than by shave excision) and repair of, if:	on),
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguo area; and	us
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31360	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$170.75 <b>Benefit:</b> 75% = \$128.10 85% = \$145.15	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	374,
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to including, the	, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31361	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$189.70 <b>Benefit:</b> 75% = \$142.30 85% = \$161.25	

T8. SUF	RGICAL OPERATIONS 1. GEN	ERAL
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operat surgical excision (other than by shave excision) and repair of, if:	ion),
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal including, the	to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
31362	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$136.05 <b>Benefit:</b> 75% = \$102.05  85% = \$115.65	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 3 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	1374,
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal including, the	to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
31363	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$248.20 <b>Benefit:</b> 75% = \$186.15  85% = \$211.00	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operat surgical excision (other than by shave excision) and repair of, if:	ion),
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal including, the	to, and
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31364	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$170.75 <b>Benefit:</b> 75% = \$128.10 85% = \$145.15	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 3 or 31373), surgical excision (other than by shave excision) and repair of, if:	1372
21265	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31 31363; and	361 or
31365		

T8. SURC	GICAL OPERATIONS	1. GENERAL
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$160.85 <b>Benefit:</b> 75% = \$120.65 85% = \$136.75	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic ke including a cyst, ulcer or scar (other than a scar removed during the surgical approach a surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360, and	31362 or 31364;
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
31366	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$97.00 <b>Benefit:</b> 75% = \$72.75  85% = \$82.45	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	, 31373, 31374,
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31363; and	31359, 31361 or
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31367	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$217.00 <b>Benefit:</b> 75% = \$162.75 85% = \$184.45	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic ke including a cyst, ulcer or scar (other than a scar removed during the surgical approach a surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360, and	31362 or 31364;
	(b) the necessary excision diameter is at least 15 mm but not more than 30mm; and	
	(c) the excised specimen is sent for histological examination;	
	not in association with item 45201 (Anaes.)	
31368	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$127.55 <b>Benefit:</b> 75% = \$95.70  85% = \$108.45	

T8. SUR	GICAL OPERATIONS	1. GENERAL
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 3137 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	2, 31373, 31374,
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358 31363; and	8, 31359, 31361 or
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	)
31369	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$249.85 <b>Benefit:</b> 75% = \$187.40 85% = \$212.40	
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic k including a cyst, ulcer or scar (other than a scar removed during the surgical approach surgical excision (other than by shave excision) and repair of, if:	
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360 and	0, 31362 or 31364;
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination (Anaes.)	
31370	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$145.85 <b>Benefit:</b> 75% = \$109.40 85% = \$124.00	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and repa	
	(a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or frarea; and	om a contiguous
	(b) the necessary excision diameter is 6 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	1
31371	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$362.70 <b>Benefit:</b> 75% = \$272.05  85% = \$308.30	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and repa	
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower and including,	limb (distal to,
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is less than 14 mm; and	
	(c) the excised specimen is sent for histological examination; and	
31372	(d) malignancy is confirmed from the excised specimen or previous biopsy;	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	not in association with item 45201 (Anaes.)	
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$313.65 <b>Benefit:</b> 75% = \$235.25  85% = \$266.65	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and report	
	(a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower and including,	er limb (distal to,
	the knee) or distal upper limb (distal to, and including, the ulnar styloid); and	
	(b) the necessary excision diameter is 14 mm or more; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes	.)
31373	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$362.50 <b>Benefit:</b> 75% = \$271.90  85% = \$308.15	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and report	
	(a) the tumour is excised from any part of the body not covered by item 31371, 313	372 or 31373; and
	(b) the necessary excision diameter is less than 15 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31374	(See para TN.8.125, TN.1.21 of explanatory notes to this Category) <b>Fee:</b> \$286.40 <b>Benefit:</b> 75% = \$214.80  85% = \$243.45	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and report	
	(a) the tumour is excised from any part of the body not covered by item 31371, 313	372 or 31373; and
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and	d
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy;	
	not in association with item 45201 (Anaes.)	
31375	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$308.25 <b>Benefit:</b> 75% = \$231.20 85% = \$262.05	
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and report	
31376	(a) the tumour is excised from any part of the body not covered by item 31371, 313	372 or 31373; and

T8. SUF	RGICAL OPERATIONS 1. GENER	AL
	(b) the necessary excision diameter is more than 30 mm; and	
	(c) the excised specimen is sent for histological examination; and	
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)	
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) <b>Fee:</b> \$357.25 <b>Benefit:</b> 75% = \$267.95 85% = \$303.70	
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm in diamete (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	er
31400	<b>Fee:</b> \$265.25 <b>Benefit:</b> 75% = \$198.95 85% = \$225.50	
	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.)	on
31403	<b>Fee:</b> \$306.15 <b>Benefit:</b> 75% = \$229.65	
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)	
31406	<b>Fee:</b> \$510.20 <b>Benefit:</b> 75% = \$382.65 85% = \$433.70	
	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)	
31409	<b>Fee:</b> \$1,585.10 <b>Benefit:</b> 75% = \$1188.85	
	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approa (Anaes.) (Assist.)	ch
31412	<b>Fee:</b> \$1,952.50 <b>Benefit:</b> 75% = \$1464.40	
	LYMPH NODE OF NECK, biopsy of (Anaes.)	
31420	<b>Fee:</b> \$186.85 <b>Benefit:</b> 75% = \$140.15 85% = \$158.85	
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of so tissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anaes.) (Assis	
31423	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$408.20 <b>Benefit:</b> 75% = \$306.15 85% = \$347.00	
	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)	
31426	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$816.30 <b>Benefit:</b> 75% = \$612.25	
	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.)	
31429	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$1,272.15 <b>Benefit:</b> 75% = \$954.15	
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohy dissections) (Anaes.) (Assist.)	oid

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$1,360.60 <b>Benefit:</b> 75% = \$1020.45	
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels o neck (Anaes.) (Assist.)	n one side of the
31435	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$1,000.05 <b>Benefit:</b> 75% = \$750.05	
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid accessory nerve (Anaes.) (Assist.)	
31438	(See para TN.8.24 of explanatory notes to this Category) <b>Fee:</b> \$1,585.10 <b>Benefit:</b> 75% = \$1188.85	
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, when hour or less (Anaes.) (Assist.)	re the time taken is 1
31450	<b>Fee:</b> \$413.15 <b>Benefit:</b> 75% = \$309.90	
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, when more than 1 hour (Anaes.) (Assist.)	re the time taken in
31452	<b>Fee:</b> \$722.90 <b>Benefit:</b> 75% = \$542.20	
	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (	Anaes.) (Assist.)
31454	<b>Fee:</b> \$572.30 <b>Benefit:</b> 75% = \$429.25	
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where bli feeding tube has failed or is inappropriate due to the patient's medical condition (Analysis)	
31456	<b>Fee:</b> \$249.50 <b>Benefit:</b> 75% = \$187.15	
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where bli feeding tube has failed or is inappropriate due to the patient's medical condition, and imaging intensification is clinically indicated (Anaes.)	
31458	<b>Fee:</b> \$299.35 <b>Benefit:</b> 75% = \$224.55	
	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any as services (Anaes.) (Assist.)	sociated imaging
31460	<b>Fee:</b> \$362.70 <b>Benefit:</b> 75% = \$272.05	
	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major up resection (Anaes.) (Assist.)	per gastro-intestinal
31462	<b>Fee:</b> \$529.60 <b>Benefit:</b> 75% = \$397.20	
	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic app without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a item 30601 applies (Anaes.) (Assist.)	
31464	(See para TN.8.19 of explanatory notes to this Category) <b>Fee:</b> \$885.25 <b>Benefit:</b> 75% = \$663.95	
	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic app without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or o (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATI	ONS	1. GENERAI	
	Fee: \$1,327.85	<b>Benefit:</b> 75% = \$995.90		
		AGEAL HIATUS HERNIA, repair of, with complete reduction chiatus, with or without fundoplication (Anaes.) (Assist.)	of hernia, resection of	
31468	Fee: \$1,458.80	<b>Benefit:</b> 75% = \$1094.10		
	LAPAROSCOPI	C SPLENECTOMY, on a person 10 years of age or over (Anaes.	.) (Assist.)	
31470	<b>Fee:</b> \$731.70	<b>Benefit:</b> 75% = \$548.80		
	CHOLEDOCHO.	DUODENOSTOMY, CHOLECYSTOENTEROSTOMY, JEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where ed (Anaes.) (Assist.)	e prior biliary surgery	
31472	Fee: \$1,188.50	<b>Benefit:</b> 75% = \$891.40		
		GN LESION up to and including 50mm in diameter, including significantly disease, open surgical biopsy or excision of, with or value.		
31500	(See para TN.8.25 o <b>Fee:</b> \$264.20	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$198.15 85% = \$224.60		
	BREAST, BENIC	GN LESION more than 50mm in diameter, excision of (Anaes.)	(Assist.)	
31503	(See para TN.8.25 ( <b>Fee:</b> \$352.30	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$264.25 85% = \$299.50		
		RMALITY detected by mammography or ultrasound where guiddure is performed, excision biopsy of (Anaes.) (Assist.)	dewire or other	
31506	(See para TN.8.25 ( <b>Fee:</b> \$396.35	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$297.30		
	BREAST, MALIGATION (Anaes.)	GNANT TUMOUR, open surgical biopsy of, with or without from	ozen section histology	
31509	(See para TN.8.25 <b>Fee:</b> \$352.30	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$264.25 85% = \$299.50		
	BREAST, MALIC histology (Anaes.	GNANT TUMOUR, complete local excision of, with or without ) (Assist.)	frozen section	
31512	Fee: \$660.55	<b>Benefit:</b> 75% = \$495.45		
	BREAST, TUMO tumour (Anaes.)	OUR SITE, re-excision of following open biopsy or incomplete e (Assist.)	excision of malignant	
31515	(See para TN.8.25 <b>Fee:</b> \$443.15	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$332.40		
	histology when ta	GNANT TUMOUR, complete local excision of, with or without argeted intraoperative radiotherapy (using an Intrabeam® device) he requirements of item 15900 are met for the patient (Anaes.) (Anaes.)	) is performed	
31516	Fee: \$880.85	<b>Benefit:</b> 75% = \$660.65		
	BREAST, total m	nastectomy (H) (Anaes.) (Assist.)		
31519	Fee: \$747.85	<b>Benefit:</b> 75% = \$560.90		

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.)
31524	<b>Fee:</b> \$1,056.90 <b>Benefit:</b> 75% = \$792.70
	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assisted lipolysis), not being a service associated with a service to which item 45585 applies (H) (Anaes.) (Assist.)
31525	<b>Fee:</b> \$528.30 <b>Benefit:</b> 75% = \$396.25
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated:
	(a) microcalcification of lesion; or
	(b) impalpable lesion less than 1cm in diameter
	- including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply
31530	<b>Fee:</b> \$605.20 <b>Benefit:</b> 75% = \$453.90 85% = \$520.50
	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.)
31533	(See para TN.8.26 of explanatory notes to this Category) <b>Fee:</b> \$140.10 <b>Benefit:</b> 75% = \$105.10 85% = \$119.10
	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31539, 31542 or 31545 applies (Anaes.)
31536	<b>Fee:</b> \$192.45 <b>Benefit:</b> 75% = \$144.35 85% = \$163.60
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, 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.)
31539	(See para TN.8.27 of explanatory notes to this Category) <b>Fee:</b> \$405.20 <b>Benefit:</b> 75% = \$303.90
	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 using a bore-enbloc stereotactic biopsy - including imaging not being a service associated with a service to which item 31536 applies (Anaes.)
31542	(See para TN.8.28 of explanatory notes to this Category) <b>Fee:</b> \$200.10 <b>Benefit:</b> 75% = \$150.10 85% = \$170.10
	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a bore-enbloc stereotactic biopsy, for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons; where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire or similar device, using interventional imaging techniques and including imaging not being a service associated with a service to which item 31530, 31536 or 31548 applies (Anaes.)
31545	(See para TN.8.27 of explanatory notes to this Category) <b>Fee:</b> \$605.20 <b>Benefit:</b> 75% = \$453.90 85% = \$520.50
31548	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for

RGICAL OPERAT	ONS 1. GENERAL
histological exa	nination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.)
Fee: \$140.10	<b>Benefit:</b> 75% = \$105.10 85% = \$119.10
granulomatous r	MATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, assitis or similar, exploration and drainage of when undertaken in the operating theatre luding aftercare (Anaes.)
Fee: \$220.20	<b>Benefit:</b> 75% = \$165.15
BREAST, micro	dochotomy of, for benign or malignant condition (Anaes.) (Assist.)
Fee: \$440.45	<b>Benefit:</b> 75% = \$330.35
BREAST CENT	RAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)
Fee: \$352.30	<b>Benefit:</b> 75% = \$264.25 85% = \$299.50
ACCESSORY E	REAST TISSUE, excision of (Anaes.) (Assist.)
Fee: \$352.30 Extended Medi	<b>Benefit:</b> 75% = \$264.25 85% = \$299.50 care <b>Safety Net Cap:</b> \$281.85
INVERTED NII	PLE, surgical eversion of (Anaes.)
Fee: \$263.90	<b>Benefit:</b> 75% = \$197.95 85% = \$224.35
ACCESSORY N	IPPLE, excision of (Anaes.)
<b>Fee:</b> \$132.05	<b>Benefit:</b> 75% = \$99.05 85% = \$112.25
	BARIATRIC
	c band, placement of, with or without crural repair taking 45 minutes or less, for a cally severe obesity (Anaes.) (Assist.)
(See para TN.8.29 <b>Fee:</b> \$863.15	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$647.40
minutes or less,	y Roux-en-Y including associated anastomoses, with or without crural repair taking 45 for a patient with clinically severe obesity not being associated with a service to which es (Anaes.) (Assist.)
(See para TN.8.29 <b>Fee:</b> \$1,062.15	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$796.65
	my, with or without crural repair taking 45 minutes or less, for a patient with clinically anaes.) (Assist.)
(See para TN.8.29 <b>Fee:</b> \$863.15	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$647.40
	cluding by gastric plication), with or without crural repair taking 45 minutes or less, for nically severe obesity (Anaes.) (Assist.)
(See para TN.8.29 <b>Fee:</b> \$863.15	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$647.40
and anastomoses	y biliopancreatic diversion with or without duodenal switch including gastric resection, with or without crural repair taking 45 minutes or less, for a patient with clinically knaes.) (Assist.)
(See para TN.8.29	of explanatory notes to this Category)
	Fee: \$140.10  BREAST, HAEM granulomatous m of a hospital, exc.  Fee: \$220.20  BREAST, microcon Fee: \$440.45  BREAST CENTIFIED STATE Fee: \$352.30  ACCESSORY BEAST STATE Fee: \$352.30  Extended Medicon INVERTED NIPUS Fee: \$263.90  ACCESSORY NOTES Fee: \$132.05  Adjustable gastric patient with clinical (See para TN.8.29)  Fee: \$863.15  Gastric bypass by minutes or less, for item 30515 applied (See para TN.8.29)  Fee: \$1,062.15  Sleeve gastrector severe obesity (ACCESSORY NOTES Fee: \$863.15)  Gastroplasty (excapation for item 10 of the para TN.8.29)  Fee: \$863.15  Gastroplasty (excapation for item 10 of the para TN.8.29)  Fee: \$863.15  Gastroplasty (excapation for item 10 of the para TN.8.29)  Fee: \$863.15  Gastroplasty (excapation for item 10 of the para TN.8.29)  Fee: \$863.15  Gastric bypass by and anastomoses, severe obesity (ACCESSORY)

T8. SUF	RGICAL OPERATI	ONS 1. GEN	NERAL	
	Fee: \$1,062.15	<b>Benefit:</b> 75% = \$796.65		
	gastroplasty (excl	of adjustable gastric banding (removal or replacement of gastric band), gastric buding by gastric plication) or biliopancreatic diversion being services to which i pply (Anaes.) (Assist.)		
31584	(See para TN.8.30 o <b>Fee:</b> \$1,563.75	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$1172.85		
	Adjustment of ga	stric band as an independent procedure including any associated consultation		
31587	<b>Fee:</b> \$99.50	<b>Benefit:</b> 75% = \$74.65 85% = \$84.60		
	Adjustment of ga	stric band reservoir, repair, revision or replacement of (Anaes.) (Assist.)		
31590	Fee: \$255.75	<b>Benefit:</b> 75% = \$191.85 85% = \$217.40		
T8. SUF	RGICAL OPERATI	ONS 2. COLORE	ECTAL	
	Group T8. Surgi	cal Operations		
		Subgroup 2. Colorectal		
		INE, resection of, without anastomosis, including right hemicolectomy (including a) (Anaes.) (Assist.)	ng	
32000	Fee: \$1,047.85	<b>Benefit:</b> 75% = \$785.90		
	LARGE INTEST	INE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (A	ssist.)	
32003	Fee: \$1,096.05	<b>Benefit:</b> 75% = \$822.05		
	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (Anaes.) (Assist.)			
32004	Fee: \$1,168.75	<b>Benefit:</b> 75% = \$876.60		
		INE, subtotal colectomy (resection of right colon, transverse colon and splenic f not being a service associated with a service to which item 32000, 32003, 3200 naes.) (Assist.)		
32005	Fee: \$1,320.35	<b>Benefit:</b> 75% = \$990.30		
	LEFT HEMICOI stoma) (Anaes.) (	ECTOMY, including the descending and sigmoid colon (including formation of Assist.)	f	
32006	<b>Fee:</b> \$1,168.75	<b>Benefit:</b> 75% = \$876.60		
	TOTAL COLEC	TOMY AND ILEOSTOMY (Anaes.) (Assist.)		
32009	Fee: \$1,386.45	<b>Benefit:</b> 75% = \$1039.85		
	TOTAL COLEC	TOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.)		
32012	Fee: \$1,531.50	<b>Benefit:</b> 75% = \$1148.65		
		FOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anae	s.)	
32015	Fee: \$1,882.15	<b>Benefit:</b> 75% = \$1411.65		
32018	TOTAL COLEC	TOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED		

T8. SUF	RGICAL OPERATION	ONS	2. COLORECTAL	
	SYNCHRONOUS	OPERATION; ABDOMINAL R	ESECTION (including aftercare) (Anaes.) (Assist.)	
	Fee: \$1,596.00	<b>Benefit:</b> 75% = \$1197.00		
		OMY WITH EXCISION OF REG OPERATION; PERINEAL RES	CTUM AND ILEOSTOMY, COMBINED ECTION (Assist.)	
32021	<b>Fee:</b> \$572.30	<b>Benefit:</b> 75% = \$429.25		
		ion of stent or stents for large bow any image intensification, where the	el obstruction, stricture or stenosis, including ne obstruction is due to:	
	a) a pre-diagnosed colorectal cancer, or cancer of an organ adjacent to the bowel; or			
	b) an unkno	own diagnosis (Anaes.)		
32023	(See para TN.8.17 o <b>Fee:</b> \$564.25	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$423.20		
	ANASTOMOSIS	(of the rectum) greater than 10 cene not being a service associated v	ESECTION WITH INTRAPERITONEAL ntimetres from the anal verge excluding resection of with a service to which item 32103, 32104 or 32106	
32024	Fee: \$1,386.45	<b>Benefit:</b> 75% = \$1039.85		
	ANASTOMOSIS	(of the rectum) less than 10 centir	SECTION WITH EXTRAPERITONEAL netres from the anal verge, with or without covering o which item 32103, 32104 or 32106 applies	
32025	<b>Fee:</b> \$1,854.50	<b>Benefit:</b> 75% = \$1390.90		
			TION, with or without covering stoma, where the m or less from the anal verge (Anaes.) (Assist.)	
32026	<b>Fee:</b> \$1,997.10	<b>Benefit:</b> 75% = \$1497.85		
		OR ULTRA LOW RESTORATIVO or without covering stoma (Anaes	/E RESECTION, with peranal sutured coloanal s.) (Assist.)	
32028	<b>Fee:</b> \$2,139.90	<b>Benefit:</b> 75% = \$1604.95		
		RVOIR, construction of, being a soup applies (Anaes.) (Assist.)	ervice associated with a service to which any other	
32029	Fee: \$427.95	<b>Benefit:</b> 75% = \$321.00		
	RECTOSIGMOII	DECTOMY (Hartmann's operation	n) (Anaes.) (Assist.)	
32030	<b>Fee:</b> \$1,047.85	<b>Benefit:</b> 75% = \$785.90		
	RESTORATION stoma (Anaes.) (A	_	s or similar operation, including dismantling of the	
32033	<b>Fee:</b> \$1,531.50	<b>Benefit:</b> 75% = \$1148.65		
	SACROCOCCYC	GEAL AND PRESACRAL TUMO	OUR excision of (Anaes.) (Assist.)	
32036	<b>Fee:</b> \$1,942.40	<b>Benefit:</b> 75% = \$1456.80		

T8. SUF	GICAL OPERATIO	NS	2. COLORECTAL
	RECTUM AND A	NUS, ABDOMINOPERINEAL RI	ESECTION OF 1 surgeon (Anaes.) (Assist.)
32039	Fee: \$1,559.60	<b>Benefit:</b> 75% = \$1169.70	
		NUS, ABDOMINOPERINEAL RI ominal resection (Anaes.) (Assist.)	ESECTION OF, COMBINED SYNCHRONOUS
32042	Fee: \$1,313.85	<b>Benefit:</b> 75% = \$985.40	
		NUS, ABDOMINOPERINEAL RI neal resection (Assist.)	ESECTION OF, COMBINED SYNCHRONOUS
32045	<b>Fee:</b> \$491.70	<b>Benefit:</b> 75% = \$368.80	
			f, combined synchronous operation - perineal sistance to the abdominal surgeon (Assist.)
32046	Fee: \$759.85	<b>Benefit:</b> 75% = \$569.90	
	PERINEAL PROC	TECTOMY (Anaes.) (Assist.)	
32047	Fee: \$885.25	<b>Benefit:</b> 75% = \$663.95	
		DMY with excision of rectum and rithout creation of temporary ileost	ileoanal anastomosis with formation of ileal omy 1 surgeon (Anaes.) (Assist.)
32051	Fee: \$2,353.65	<b>Benefit:</b> 75% = \$1765.25	
		ithout creation of temporary ileost	ileoanal anastomosis with formation of ileal omy conjoint surgery, abdominal surgeon
32054	Fee: \$2,160.20	<b>Benefit:</b> 75% = \$1620.15	
		DMY with excision of rectum and surgery, perineal surgeon (Assist.)	ileoanal anastomosis with formation of ileal
32057	Fee: \$572.30	<b>Benefit:</b> 75% = \$429.25	
			ucosectomy and ileoanal anastomosis with loop ileostomy 1 surgeon (Anaes.) (Assist.)
32060	Fee: \$2,353.65	<b>Benefit:</b> 75% = \$1765.25	
	formation of ileal re		sucosectomy and ileoanal anastomosis with v loop ileostomy conjoint surgery, abdominal
32063	Fee: \$2,160.20	<b>Benefit:</b> 75% = \$1620.15	
			ucosectomy and ileoanal anastomosis with loop ileostomy conjoint surgery, perineal
32066	<b>Fee:</b> \$572.30	<b>Benefit:</b> 75% = \$429.25	
	ILEOSTOMY RES	• •	of, including conversion of existing ileostomy
32069	Fee: \$1,741.05	<b>Benefit:</b> 75% = \$1305.80	
32072	SIGMOIDOSCOPI	C EXAMINATION (with rigid sig	gmoidoscope), with or without biopsy

GICAL OPERAT	IONS	2. COLOREC	ΓAL	
Fee: \$48.60	<b>Benefit:</b> 75% = \$36.45	85% = \$41.35		
ANAESTHESIA	A, with or without biopsy, no		her	
Fee: \$76.25	<b>Benefit:</b> 75% = \$57.20	85% = \$64.85		
			ıt	
(Anaes.)				
(See para TN.8.17 <b>Fee:</b> \$113.15				
fibreoptic colon angiodysplasia o	oscopy for the removal of 1 or post-polypectomy bleeding	or more polyps or the treatment of radiation proctitis, ng by argon plasma coagulation, one or more of, other that		
(Anaes.)				
(See para TN.8.17 <b>Fee:</b> \$208.00				
ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.)				
(See para TN.8.17 <b>Fee:</b> \$560.70				
		LL BOWEL with flexible endoscope passed by stoma, wi	th	
(See para TN.8.17 <b>Fee:</b> \$129.85				
			)	
Fee: \$261.05	<b>Benefit:</b> 75% = \$195.80	0		
RECTAL TUM (Assist.)	OUR of 5 centimetres or less	ss in diameter, per anal submucosal excision of (Anaes.)		
Fee: \$338.55	<b>Benefit:</b> 75% = \$253.95	5		
			n,	
Fee: \$644.85	<b>Benefit:</b> 75% = \$483.65	5		
either 3 dimensiduring colonosc	onal or 2 dimensional optic oppy or by local excision, oth	viewing systems, if removal is unable to be performed her than a service associated with a service to which item		
(See para TN.8.31	, TN.8.17 of explanatory notes	s to this Category)		
	Fee: \$48.60  SIGMOIDOSCO ANAESTHESIA item in this Grou Fee: \$76.25  Flexible fibreopy biopsy, other that  (Anaes.)  (See para TN.8.17 Fee: \$113.15  Endoscopic exantibreoptic colonic angiodysplasia of service associated (Anaes.)  (See para TN.8.17 Fee: \$208.00  ENDOSCOPIC  (See para TN.8.17 Fee: \$560.70  ENDOSCOPIC or without biops  (See para TN.8.17 Fee: \$129.85  RECTAL BIOP onerve block wheeler \$261.05  RECTAL TUMO (Assist.)  Fee: \$338.55  RECTAL TUMO (Assist.)  Fee: \$644.85  RECTAL TUMO (Assist.)  Fee: \$644.85	Fee: \$48.60 Benefit: 75% = \$36.45  SIGMOIDOSCOPIC EXAMINATION (with ANAESTHESIA, with or without biopsy, note item in this Group applies (Anaes.)  Fee: \$76.25 Benefit: 75% = \$57.20  Flexible fibreoptic sigmoidoscopy or fibreophic biopsy, other than a service associated with (Anaes.)  (See para TN.8.17, TN.8.134 of explanatory note fibreoptic colonoscopy for the removal of 1 angiodysplasia or post-polypectomy bleeding service associated with a service to which a (Anaes.)  (See para TN.8.17, TN.8.134 of explanatory note fibreoptic colonoscopy for the removal of 1 angiodysplasia or post-polypectomy bleeding service associated with a service to which a (Anaes.)  (See para TN.8.17, TN.8.134 of explanatory note fee: \$208.00 Benefit: 75% = \$156.00  ENDOSCOPIC DILATATION OF COLOI (See para TN.8.17 of explanatory notes to this Continuous fee: \$208.00 Benefit: 75% = \$420.50  ENDOSCOPIC EXAMINATION of SMAI or without biopsies (Anaes.)  (See para TN.8.17 of explanatory notes to this Continuous fee: \$129.85 Benefit: 75% = \$97.40  RECTAL BIOPSY, full thickness, under generve block where undertaken in a hospital fee: \$261.05 Benefit: 75% = \$195.80  RECTAL TUMOUR of 5 centimetres or less (Assist.)  Fee: \$338.55 Benefit: 75% = \$483.60  RECTAL TUMOUR, of less than 4 cm in ceither 3 dimensional or 2 dimensional optic during colonoscopy or by local excision, of 32024, 32025, 32104 or 32106 applies (Anaesion) and 52024, 32025, 32104 or 32106 applies (Anaesion)	Fee: \$48.60   Benefit: 75% = \$36.45   85% = \$41.35     SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which anot item in this Group applies (Anaes.)   Fee: \$76.25   Benefit: 75% = \$57.20   85% = \$64.85     Flexible fibreoptic sigmoidoscopy or fibreoptic colonoscopy up to the hepatic flexure, with or without biopsy, other than a service associated with a service to which any of items 32222 to 32228 applies.  (Anaes.)  (See para TN.8.17, TN.8.134 of explanatory notes to this Category)   Fee: \$113.15   Benefit: 75% = \$84.90   85% = \$96.20     Endoscopic examination of the colon up to the hepatic flexure by flexible fibreoptic sigmoidoscopy of fibreoptic colonoscopy for the removal of 1 or more polyps or the treatment of radiation proctitis, angiodysplasia or post-polypectomy bleeding by argon plasma coagulation, one or more of, other thas service associated with a service to which any of items 32222 to 32228 applies  (Anaes.)  (See para TN.8.17, TN.8.134 of explanatory notes to this Category)   Fee: \$208.00   Benefit: 75% = \$156.00   85% = \$176.80    ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.)  (See para TN.8.17 of explanatory notes to this Category)   Fee: \$560.70   Benefit: 75% = \$420.55    ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, wire without biopsies (Anaes.)  (See para TN.8.17 of explanatory notes to this Category)   Fee: \$129.85   Benefit: 75% = \$97.40   85% = \$110.40    RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal nerve block where undertaken in a hospital (Anaes.) (Assist.)  Fee: \$261.05   Benefit: 75% = \$195.80    RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (Anaes.) (Assist.)  Fee: \$338.55   Benefit: 75% = \$253.95    RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination per anal submucosal exci	

T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL	
	Fee: \$784.65	<b>Benefit:</b> 75% = \$588.50		
	incorporating eit performed during	DUR, of 4 cm or greater in diameter, per anal excision of ther 3 dimensional or 2 dimensional optic viewing systems colonoscopy or by local excision, other than a service 4, 32025, 32103 or 32106 applies (Anaes.) (Assist.)	ns, if removal is unable to be	
32104	(See para TN.8.31 <b>Fee:</b> \$1,015.65	TN.8.17 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$761.75		
	ANORECTAL O	CARCINOMA per anal full thickness excision of (Anae	es.) (Assist.)	
32105	<b>Fee:</b> \$491.70	<b>Benefit:</b> 75% = \$368.80 85% = \$417.95		
	rectoscopy incor unable to be perf	RAL INTRAPERITONEAL RECTAL TUMOUR, per a porating either 3 dimensional or 2 dimensional optic viewormed during colonoscopy and if removal requires dissent a service associated with a service to which item 32024 (Assist.)	ewing systems, if removal is ection within the peritoneal	
		, TN.8.17 of explanatory notes to this Category)		
32106	Fee: \$1,386.45	<b>Benefit:</b> 75% = \$1039.85  85% = \$1301.75	· · · · · · · · · · · · · · · · · · ·	
	RECTAL TUMO	DUR, transsphincteric excision of (Kraske or similar ope	eration) (Anaes.) (Assist.)	
32108	Fee: \$1,015.65	<b>Benefit:</b> 75% = \$761.75		
	RECTAL PROL	APSE Delorme procedure for (Anaes.) (Assist.)		
32111	Fee: \$644.85	<b>Benefit:</b> 75% = \$483.65		
	RECTAL PROL	APSE, perineal recto-sigmoidectomy for (Anaes.) (Assi	st.)	
32112	Fee: \$784.65	<b>Benefit:</b> 75% = \$588.50		
	RECTAL STRICTURE, per anal release of (Anaes.)			
32114	Fee: \$177.25	<b>Benefit:</b> 75% = \$132.95 85% = \$150.70		
	RECTAL STRIC	CTURE, dilatation of (Anaes.)		
32115	Fee: \$128.90	<b>Benefit:</b> 75% = \$96.70		
		APSE, abdominal rectopexy of (Anaes.) (Assist.)		
32117	Fee: \$1,015.65	<b>Benefit:</b> 75% = \$761.75		
32117	· ·	APSE, perineal repair of (Anaes.) (Assist.)		
22120				
32120	Fee: \$261.05	Benefit: 75% = \$195.80 URE, anoplasty for (Anaes.) (Assist.)		
32123	Fee: \$338.55	<b>Benefit:</b> 75% = \$253.95 85% = \$287.80	× ( <b>A</b> · ' · ( )	
	ANAL INCONT	TNENCE, Parks' intersphincteric procedure for (Anaes.)	) (Assist.)	
32126	Fee: \$491.70	<b>Benefit:</b> 75% = \$368.80		
	ANAL SPHINC	TER, direct repair of (Anaes.) (Assist.)		
32129	Fee: \$644.85	<b>Benefit:</b> 75% = \$483.65		

T8. SUF	RGICAL OPERAT	IONS 2. COLORECTAL
	RECTOCELE, t	ransanal repair of rectocele (Anaes.) (Assist.)
32131	Fee: \$542.15	<b>Benefit:</b> 75% = \$406.65
	HAEMORRHO	IDS OR RECTAL PROLAPSE sclerotherapy for (Anaes.)
32132	Fee: \$45.80	<b>Benefit:</b> 75% = \$34.35 85% = \$38.95
		IDS OR RECTAL PROLAPSE rubber band ligation of, with or without sclerotherapy, nfra red therapy for (Anaes.)
32135	Fee: \$68.60	<b>Benefit:</b> 75% = \$51.45 85% = \$58.35
	HAEMORRHO	IDECTOMY including excision of anal skin tags when performed (Anaes.)
32138	Fee: \$373.65	<b>Benefit:</b> 75% = \$280.25 85% = \$317.65
		IDECTOMY involving third or fourth degree haemorrhoids, including excision of anal performed (Anaes.) (Assist.)
32139	Fee: \$373.65	<b>Benefit:</b> 75% = \$280.25
	ANAL SKIN TA	AGS or ANAL POLYPS, excision of 1 or more of (Anaes.)
32142	Fee: \$68.60	<b>Benefit:</b> 75% = \$51.45 85% = \$58.35
	ANAL SKIN TA a hospital (Anae	AGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of s.)
32145	Fee: \$137.20	<b>Benefit:</b> 75% = \$102.90
	PERIANAL TH	ROMBOSIS, incision of (Anaes.)
32147	<b>Fee:</b> \$45.80	<b>Benefit:</b> 75% = \$34.35 85% = \$38.95
	OPERATION For only (Anaes.) (A	OR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation assist.)
32150	Fee: \$261.05	<b>Benefit:</b> 75% = \$195.80 85% = \$221.90
		ATION OF, under general anaesthesia, with or without disimpaction of faeces, not being ted with a service to which another item in this Group applies (Anaes.)
32153	Fee: \$71.20	<b>Benefit:</b> 75% = \$53.40
	FISTULA-IN-A	NO, SUBCUTANEOUS, excision of (Anaes.)
32156	Fee: \$133.85	<b>Benefit:</b> 75% = \$100.40 85% = \$113.80
		A, treatment of, by excision or by insertion of a Seton, or by a combination of both lving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)
32159	Fee: \$338.55	<b>Benefit:</b> 75% = \$253.95
		A, treatment of, by excision or by insertion of a Seton, or by a combination of both living the upper half of the anal sphincter mechanism (Anaes.) (Assist.)
32162	<b>Fee:</b> \$491.70	<b>Benefit:</b> 75% = \$368.80
	ANAL FISTUL	A, repair of, by mucosal flap advancement (Anaes.) (Assist.)
32165	Fee: \$644.85	<b>Benefit:</b> 75% = \$483.65 85% = \$560.15

T8. SUF	RGICAL OPERATION	ONS 2. COLORECTAL
	ANAL FISTULA	- readjustment of Seton (Anaes.)
32166	Fee: \$209.50	<b>Benefit:</b> 75% = \$157.15 85% = \$178.10
	FISTULA WOUN (Anaes.)	ND, review of, under general or regional anaesthetic, as an independent procedure
32168	Fee: \$133.85	<b>Benefit:</b> 75% = \$100.40
		XAMINATION, with or without biopsy, under general anaesthetic, not being a service service to which another item in this Group applies (Anaes.)
32171	Fee: \$90.20	<b>Benefit:</b> 75% = \$67.65
	INTR-AANAL, p	erianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)
32174	Fee: \$90.20	<b>Benefit:</b> 75% = \$67.65 85% = \$76.70
	· ·	ERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating al (excluding aftercare) (Anaes.)
32175	Fee: \$165.25	<b>Benefit:</b> 75% = \$123.95
	(excluding puden	removal of, under general anaesthesia, or under regional or field nerve block dal block) requiring admission to a hospital, where the time taken is less than or equal at being a service associated with a service to which item 35507 or 35508 applies
32177	<b>Fee:</b> \$177.05	<b>Benefit:</b> 75% = \$132.80
	(excluding puden	removal of, under general anaesthesia, or under regional or field nerve block dal block) requiring admission to a hospital, where the time taken is greater than 45 g a service associated with a service to which item 35507 or 35508 applies (Anaes.)
32180	<b>Fee:</b> \$261.05	<b>Benefit:</b> 75% = \$195.80
	INTESTINAL SL	ING PROCEDURE prior to radiotherapy (Anaes.) (Assist.)
32183	<b>Fee:</b> \$570.65	<b>Benefit:</b> 75% = \$428.00
	COLONIC LAVA	AGE, total, intra operative (Anaes.) (Assist.)
32186	Fee: \$570.65	<b>Benefit:</b> 75% = \$428.00
	DISTAL MUSCL	E, devascularisation of (Anaes.) (Assist.)
32200	Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35 85% = \$255.40
	ANAL OR PERI	NEAL GRACILOPLASTY (Anaes.) (Assist.)
32203	<b>Fee:</b> \$645.15	<b>Benefit:</b> 75% = \$483.90
	STIMULATOR A	AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.)
32206	Fee: \$582.90	<b>Benefit:</b> 75% = \$437.20
	ANAL OR PERII (Assist.)	NEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.)
32209	<b>Fee:</b> \$936.70	<b>Benefit:</b> 75% = \$702.55
	GRACILIS NEO	SPHINCTER PACEMAKER, replacement of (Anaes.)
32210	Fee: \$259.55	<b>Benefit:</b> 75% = \$194.70 85% = \$220.65
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T8. SUR	GICAL OPERATIONS	2. COLORECTAL
	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation preformed in the operating theatre of a hospital, excluding aftercare (Anaes.)	octitis, where
32212	<b>Fee:</b> \$138.45 <b>Benefit:</b> 75% = \$103.85	
	Sacral nerve lead or leads, percutaneous placement using fluoroscopic guidance (cintraoperative test stimulation, to manage faecal incontinence in a patient who:	or open placement) and
	a) has an anatomically intact but functionally deficient anal sphincter; and	
	b) has faecal incontinence that has been refractory to conservative non-surgical tremonths;	eatment for at least 12
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months (Anaes.)	
32213	<b>Fee:</b> \$671.55 <b>Benefit:</b> 75% = \$503.70	
	Neurostimulator or receiver, subcutaneous placement of, involving placement and extension wire to a sacral nerve electrode using fluoroscopic guidance, to manage a patient who:	
	a) has an anatomically intact but functionally deficient anal sphincter; and	
	b) has faecal incontinence that has been refractory to conservative non-surgical tremonths;	eatment for at least 12
	other than a patient who:	
	c) is medically unfit for surgery; or	
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
32214	h) has anorectal organic bowel disease, including cancer; or	

## **T8. SURGICAL OPERATIONS** 2. COLORECTAL i) has functional effects of previous pelvic irradiation; or i) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) (Assist.) Fee: \$339.35 **Benefit:** 75% = \$254.55 Sacral nerve electrode or electrodes, management, adjustment and electronic programming of the neurostimulator by a medical practitioner, to manage faecal incontinence, other than in a patient who: a) is medically unfit for surgery; or b) is pregnant or planning pregnancy; or c) has irritable bowel syndrome; or d) has congenital anorectal malformations; or e) has active anal abscesses or fistulas; or f) has anorectal organic bowel disease, including cancer; or g) has functional effects of previous pelvic irradiation; or h) has congenital or acquired malformations of the sacrum; or i) has had rectal or anal surgery within the previous 12 months each day 32215 Fee: \$127.40 **Benefit:** 75% = \$95.55 85% = \$108.30 Sacral nerve lead or leads, percutaneous surgical repositioning of, using fluoroscopic guidance (or open surgical repositioning of) and interoperative test stimulation, to correct displacement or unsatisfactory positioning, if the lead was inserted to manage faecal incontinence in a patient who: a) has an anatomically intact but functionally deficient anal sphincter; and b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months; other than a patient who: c) is medically unfit for surgery; or d) is pregnant or planning pregnancy; or e) has irritable bowel syndrome; or f) has congenital anorectal malformations; or g) has active anal abscesses or fistulas; or h) has anorectal organic bowel disease, including cancer; or 32216

T8. SUR	GICAL OPERATIONS 2. COLORECTAL
	i) has functional effects of previous pelvic irradiation; or
	j) has congenital or acquired malformations of the sacrum; or
	k) has had rectal or anal surgery within the previous 12 months
	other than a service to which item 32213 applies
	(Anaes.)
	<b>Fee:</b> \$603.05 <b>Benefit:</b> 75% = \$452.30
	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted to manage faecal incontinence in a patient who:
	a) has an anatomically intact but functionally deficient anal sphincter; and
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;
	other than a patient who:
	c) is medically unfit for surgery; or
	d) is pregnant or planning pregnancy; or
	e) has irritable bowel syndrome; or
	f) has congenital anorectal malformations; or
	g) has active anal abscesses or fistulas; or
	h) has anorectal organic bowel disease, including cancer; or
	i) has functional effects of previous pelvic irradiation; or
	j) has congenital or acquired malformations of the sacrum; or
	k) has had rectal or anal surgery within the previous 12 months
	(Anaes.)
32217	<b>Fee:</b> \$158.80 <b>Benefit:</b> 75% = \$119.10
	Sacral nerve lead or leads, removal of, if the lead was inserted to manage faecal incontinence in a patient who:
	a) has an anatomically intact but functionally deficient anal sphincter; and
	b) has faecal incontinence that has been refractory to conservative non-surgical treatment for at least 12 months;
	other than a patient who:
	c) is medically unfit for surgery; or
32218	d) is pregnant or planning pregnancy; or

T8. SUR	GICAL OPERATIONS 2. COLORECT	ΓAL
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months	
	(Anaes.)	
	<b>Fee:</b> \$158.80 <b>Benefit:</b> 75% = \$119.10	
	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. Contraindicated in:	r
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and	
	(b) patients who have had an adverse reaction or radiopaque solution; and	
	(c) patients who enage in receptive anal intercourse (Anaes.) (Assist.)	
32220	<b>Fee:</b> \$918.35 <b>Benefit:</b> 75% = \$688.80 85% = \$833.65	
	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. Contraindicated in:	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases or a scarred or fragile perineum; and	
	(b) patients who have had an adverse reaction to radiopaque solution; and	
	(c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)	
32221	<b>Fee:</b> \$918.35 <b>Benefit:</b> 75% = \$688.80 85% = \$833.65	
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient:	
	(a) following a positive faecal occult blood test; or	
	(b) who has symptoms consistent with pathology of the colonic mucosa; or	
	(c) with anaemia or iron deficiency; or	
	(d) for whom diagnostic imaging has shown an abnormality of the colon; or	
	(e) who is undergoing the first examination following surgery for colorectal cancer; or	
	(f) who is undergoing pre-operative evaluation; or	
32222	(g) for whom a repeat colonoscopy is required due to inadequate bowel preparation for the patient's	

T8. SUR	GICAL OPERATIONS 2. COLORECTA
	previous colonoscopy; or
	(h) for the management of inflammatory bowel disease
	Applicable only once on a day under a single episode of anaesthesia or other sedation (Anaes.)
	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$339.70 <b>Benefit:</b> 75% = \$254.80  85% = \$288.75
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient:
	(a) who has had a colonoscopy that revealed 1 to 4 adenomas, each of which were less than 10mm in diameter, had no villous features and had no high grade dysplasia; or
	(b) with a moderate risk of colorectal cancer due to family history; or
	(c) with a history of colorectal cancer, who has had an initial post-operative colonoscopy that did not reveal any adenomas or colorectal cancer
	Applicable only once in any 5 year period (Anaes.)
32223	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$339.70 <b>Benefit:</b> 75% = \$254.80  85% = \$288.75
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a moderate risk of colorectal cancer due to:
	(a) a history of adenomas, including an adenoma that:
	(i) was greater than 10mm in diameter; or
	(ii) had villous features; or
	(iii) had high grade dysplasia; or
	(iv) was an advanced serrated adenoma; or
	(b) having had a previous colonoscopy that revealed 5 to 9 adenomas, each of which was less than 10mm in diameter, had no villous features and had no high grade dysplasia
	Applicable only once in any 3 year period (Anaes.)
32224	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$339.70 <b>Benefit:</b> 75% = \$254.80 85% = \$288.75
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of colorectal cancer due to having had a previous colonoscopy that:
	(a) revealed 10 or more adenomas; or
	(b) included a piecemeal, or possibly incomplete, excision of a large, sessile polyp
	Applicable not more than 4 times in any 12 month period (Anaes.)
32225	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$339.70 <b>Benefit:</b> 75% = \$254.80 85% = \$288.75
32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient with a high risk of

T8. SUF	RGICAL OPERATIONS 2.	COLORECTAL
	colorectal cancer due to:	
	(a) a known or suspected familial condition, such as familial adenomatous polyposis, L or serrated polyposis syndrome; or	ynch syndrome
	(b) a genetic mutation associated with hereditary colorectal cancer	
	Applicable only once in any 12 month period (Anaes.)	
	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) <b>Fee:</b> \$339.70 <b>Benefit:</b> 75% = \$254.80 85% = \$288.75	
	Endoscopic examination of the colon to the caecum by colonoscopy:	
	(a) for the treatment of bleeding, including one or more of the following:	
	(i) radiation proctitis;	
	(ii) angioectasia;	
	(iii) post-polypectomy bleeding; or	
	(b) for the treatment of colonic strictures with balloon dilatation	
	Applicable only once on a day under a single episode of anaesthesia or other sedation (A	Anaes.)
32227	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$476.70 <b>Benefit:</b> 75% = \$357.55  85% = \$405.20	
	Endoscopic examination of the colon to the caecum by colonoscopy, other that a service 32222, 32223, 32224, 32225, or 32226 applies. Applicable only once (Anaes.)	e to which item
32228	(See para TN.8.17, TN.8.2, TN.8.152 of explanatory notes to this Category) <b>Fee:</b> \$339.70 <b>Benefit:</b> 75% = \$254.80 85% = \$288.75	
	Removal of one or more polyps during colonoscopy, in association with a service to wh 32223, 32224, 32225, 32226, or 32228 applies	nich item 32222,
	(Anaes.)	
32229	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$274.00 <b>Benefit:</b> 75% = \$205.50  85% = \$232.90	
T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	Group T8. Surgical Operations	
	Subgroup 3. Vascular	
	VARICOSE VEINS	
	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple sclerosant using continuous compression techniques, including associated consultation not being a service associated with any other varicose vein operation on the same leg (e care) - to a maximum of 6 treatments in a 12 month period (Anaes.)	- 1 or both legs -
32500	(See para TN.8.4, TN.8.32 of explanatory notes to this Category)  Fee: \$111.55  Benefit: 75% = \$83.70  85% = \$94.85  Extended Medicare Safety Net Cap: \$122.75	

T8. SUF	RGICAL OPERATIONS 3. VASCULAR
	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 TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$271.95 <b>Benefit:</b> 75% = \$204.00 85% = \$231.20
32504	Extended Medicare Safety Net Cap: \$217.60
	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.)
32507	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$542.15 <b>Benefit:</b> 75% = \$406.65 <b>Extended Medicare Safety Net Cap:</b> \$433.75
	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32508	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$542.15 <b>Benefit:</b> 75% = \$406.65
	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32511	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$806.00 <b>Benefit:</b> 75% = \$604.50
	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32514	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$941.65 <b>Benefit:</b> 75% = \$706.25
	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32517	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$1,212.50 <b>Benefit:</b> 75% = \$909.40
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a laser probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)
32520	

T8. SUR	RGICAL OPERATIONS 3. VASCULA
	(See para TN.8.33 of explanatory notes to this Category) <b>Fee:</b> \$542.15
	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, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate embolisation, an not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)
32522	(See para TN.8.33 of explanatory notes to this Category) <b>Fee:</b> \$806.00 <b>Benefit:</b> 75% = \$604.50 85% = \$721.30 <b>Extended Medicare Safety Net Cap:</b> \$80.60
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds of longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including endovenous laser therapy or cyanoacrylate embolisation; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)
32523	(See para TN.8.33 of explanatory notes to this Category) <b>Fee:</b> \$542.15
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using a radiofrequency catheter introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including endovenous laser therapy or cyanoacrylate embolisation; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507 (Anaes.)
32526	(See para TN.8.33 of explanatory notes to this Category) <b>Fee:</b> \$806.00 <b>Benefit:</b> 75% = \$604.50 85% = \$721.30 <b>Extended Medicare Safety Net Cap:</b> \$80.60
32528	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great or small saphenous vein

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	(whichever is to be treated) demonstrates reflux of 0.5 seconds or longer:	
	(a) including all preparation and immediate clinical aftercare (including excision or tributaries or incompetent perforating veins, or both); and	injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous	laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500,	32504 and 32507
	(Anaes.)	
	(See para TN.8.33 of explanatory notes to this Category)  Fee: \$542.15  Benefit: 75% = \$406.65  Extended Medicare Safety Net Cap: \$81.35	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent gr (short) saphenous vein of one leg (and major tributaries of saphenous veins as necest cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and veins demonstrate reflux of 0.5 seconds or longer:	ssary), using
	(a) including all preparation and immediate clinical aftercare (including excision or tributaries or incompetent perforating veins, or both); and	injection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous	laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500,	32504 and 32507
	(Anaes.)	
32529	(See para TN.8.33 of explanatory notes to this Category) <b>Fee:</b> \$806.00 <b>Benefit:</b> 75% = \$604.50 85% = \$721.30 <b>Extended Medicare Safety Net Cap:</b> \$80.60	
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISE	ASE
	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.)	
32700	<b>Fee:</b> \$1,459.30 <b>Benefit:</b> 75% = \$1094.50	
	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection or reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)	f small length and
32703	<b>Fee:</b> \$1,207.20 <b>Benefit:</b> 75% = \$905.40	
	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anac	es.) (Assist.)
32708	<b>Fee:</b> \$1,444.10 <b>Benefit:</b> 75% = \$1083.10	
	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both ana arteries (Anaes.) (Assist.)	stomoses to the iliac
32710	<b>Fee:</b> \$1,604.55 <b>Benefit:</b> 75% = \$1203.45	
	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both ana	stomoses to the
	common femoral or profunda femoris arteries (Anaes.) (Assist.)	
32711	<b>Fee:</b> \$1,765.05 <b>Benefit:</b> 75% = \$1323.80	
	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.)	
32712	<b>Fee:</b> \$1,275.90 <b>Benefit:</b> 75% = \$956.95	

T8. SUF	RGICAL OPERATI	ONS	3. VASCULAR
	AXILLARY or S ARTERIES (Ana		ASS GRAFTING to 1 or both FEMORAL
32715	Fee: \$1,275.90	<b>Benefit:</b> 75% = \$956.95	
	FEMORO-FEMO	RAL OR ILIO-FEMORAL CROSS	OVER BYPASS GRAFTING (Anaes.) (Assist.)
32718	<b>Fee:</b> \$1,207.20	<b>Benefit:</b> 75% = \$905.40	
	. ,	Y, bypass grafting to (Anaes.) (Assist	i.)
32721	<b>Fee:</b> \$1,917.55	<b>Benefit:</b> 75% = \$1438.20	
02,21		ES (both), bypass grafting to (Anaes	.) (Assist.)
32724	<b>Fee:</b> \$2,177.40	<b>Benefit:</b> 75% = \$1633.05	
32721		ESSEL (single), bypass grafting to (	Anaes.) (Assist.)
32730	<b>Fee:</b> \$1,650.30	<b>Benefit:</b> 75% = \$1237.75	
32730		ESSELS (multiple), bypass grafting	to (Anaes.) (Assist.)
32733	<b>Fee:</b> \$1,917.55	<b>Benefit:</b> 75% = \$1438.20	
32133		<u></u>	when performed in conjunction with another intra-
		ar operation (Anaes.) (Assist.)	F
32736	<b>Fee:</b> \$420.15	<b>Benefit:</b> 75% = \$315.15	
		ERY BYPASS GRAFTING using very phenous vein) with above knee anast	ein, including harvesting of vein (when it is the omosis (Anaes.) (Assist.)
32739	<b>Fee:</b> \$1,314.10	<b>Benefit:</b> 75% = \$985.60	
			ein, including harvesting of vein (when it is the s to below knee popliteal artery (Anaes.) (Assist.)
32742	Fee: \$1,505.20	<b>Benefit:</b> 75% = \$1128.90	
	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.)		
32745	Fee: \$1,719.00	<b>Benefit:</b> 75% = \$1289.25	
			ein, including harvesting of vein (when it is the is within 5cms of the ankle joint (Anaes.) (Assist.)
32748	Fee: \$1,864.15	<b>Benefit:</b> 75% = \$1398.15	
	FEMORAL ART below the knee (A	~ ·	enthetic graft, with lower anastomosis above or
32751	Fee: \$1,207.20	<b>Benefit:</b> 75% = \$905.40	
		s above or below the knee, including	composite graft (synthetic material and vein) with use of a cuff or sleeve of vein at 1 or both
32754	Fee: \$1,505.20	<b>Benefit:</b> 75% = \$1128.90	
32757	FEMORAL ART	ERY SEQUENTIAL BYPASS GRA	FTING, (using a vein or synthetic material) where ularise more than 1 artery - each additional artery

T8. SUF	SURGICAL OPERATIONS 3. VASCU		
	revascularised be	vond a femoral bypass (Anaes.) (Assist.)	
	<b>Fee:</b> \$420.15	<b>Benefit:</b> 75% = \$315.15	
	VEIN, HARVES	TING OF, FROM LEG OR ARM for bypass or replacement graft when not performed is the subject of the bypass or graft - each vein (Anaes.) (Assist.)	
32760	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	
		ASS GRAFTING, using vein or synthetic material, not being a service to which is Sub-group applies (Anaes.) (Assist.)	
32763	Fee: \$1,207.20	<b>Benefit:</b> 75% = \$905.40	
	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Subgroup applies, as an independent procedure (Anaes.) (Assist.)		
32766	Fee: \$802.30	<b>Benefit:</b> 75% = \$601.75	
	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Subgroup applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.)		
32769	Fee: \$278.05	<b>Benefit:</b> 75% = \$208.55	
		BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS	
	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.)		
33050	<b>Fee:</b> \$1,478.60	<b>Benefit:</b> 75% = \$1108.95	
	BYPASS GRAF	ING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.)	
33055	Fee: \$1,185.70	<b>Benefit:</b> 75% = \$889.30	
	ANEURYSM IN (Anaes.) (Assist.)	THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting	
33070	Fee: \$855.45	<b>Benefit:</b> 75% = \$641.60 85% = \$770.75	
	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without by (Assist.)		
33075	Fee: \$1,088.20	<b>Benefit:</b> 75% = \$816.15	
	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)		
33080	Fee: \$1,328.35	<b>Benefit:</b> 75% = \$996.30	
	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replaceme of vein or synthetic material (Anaes.) (Assist.)		
33100	Fee: \$1,459.30	<b>Benefit:</b> 75% = \$1094.50 85% = \$1374.60	
	· ·	EURYSM, replacement by graft (Anaes.) (Assist.)	
33103	<b>Fee:</b> \$2,047.55	<b>Benefit:</b> 75% = \$1535.70	
	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries		
	(Anaes.) (Assist.)	OMINAL ANDOR 15M, replacement by grant including re-implantation of afteries	

T8. SUF	RGICAL OPERATION	DNS	3. VASCULAR
	SUPRARENAL A of arteries (Anaes.	BDOMINAL AORTIC ANEURYSM, replacement by graf (Assist.)	ft including re-implantation
33112	Fee: \$2,146.90	<b>Benefit:</b> 75% = \$1610.20	
		BDOMINAL AORTIC ANEURYSM, replacement by tube service to which item 33116 applies (Anaes.) (Assist.)	graft, not being a service
33115	<b>Fee:</b> \$1,444.10	<b>Benefit:</b> 75% = \$1083.10	
		BDOMINAL AORTIC ANEURYSM, replacement by tube excluding associated radiological services (Anaes.) (Assist.)	
33116	Fee: \$1,421.40	<b>Benefit:</b> 75% = \$1066.05 85% = \$1336.70	
	arteries (with or w	BDOMINAL AORTIC ANEURYSM, replacement by bifur ithout excision of common iliac aneurysms) not being a ser em 33119 applies (Anaes.) (Assist.)	
33118	Fee: \$1,604.55	<b>Benefit:</b> 75% = \$1203.45	
	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or boti iliac arteries using endovascular repair procedure, excluding associated radiological services (Anaes.) (Assist.)		
33119	<b>Fee:</b> \$1,579.40	<b>Benefit:</b> 75% = \$1184.55 85% = \$1494.70	
		BDOMINAL AORTIC ANEURYSM, replacement by bifur with or without excision or bypass of common iliac aneurysm	
33121	Fee: \$1,765.05	<b>Benefit:</b> 75% = \$1323.80	
	ANEURYSM OF (Anaes.) (Assist.)	ILIAC ARTERY (common, external or internal), replacement	ent by graft - unilateral
33124	Fee: \$1,230.15	<b>Benefit:</b> 75% = \$922.65	
	ANEURYSMS Of (Anaes.) (Assist.)	FILIAC ARTERIES (common, external or internal), replac	ement by graft - bilateral
33127	<b>Fee:</b> \$1,612.15	<b>Benefit:</b> 75% = \$1209.15 85% = \$1527.45	
	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement b graft (Anaes.) (Assist.)		emosis or replacement by
33130	<b>Fee:</b> \$1,405.80	<b>Benefit:</b> 75% = \$1054.35	
	ANEURYSM OF continuity (Anaes.	VISCERAL ARTERY, dissection and ligation of arteries w ) (Assist.)	vithout restoration of
33133	Fee: \$1,054.25	<b>Benefit:</b> 75% = \$790.70	
	FALSE ANEURY (Assist.)	SM, repair of, at aortic anastomosis following previous aor	tic surgery (Anaes.)
33136	Fee: \$2,658.60	<b>Benefit:</b> 75% = \$1993.95	
	FALSE ANEURY	SM, repair of, in iliac artery and restoration of arterial conti	inuity (Anaes.) (Assist.)
33139	<b>Fee:</b> \$1,612.15	<b>Benefit:</b> 75% = \$1209.15	
33142		SM, repair of, in femoral artery and restoration of arterial c	ontinuity (Anaes.) (Assist.)

T8. SUF	. SURGICAL OPERATIONS 3. VASC		
	Fee: \$1,505.20	<b>Benefit:</b> 75% = \$1128.90 85% = \$1420.50	
	RUPTURED TH	ORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)	
33145	<b>Fee:</b> \$2,590.00	<b>Benefit:</b> 75% = \$1942.50	
	RUPTURED THE (Assist.)	ORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)	
33148	Fee: \$3,216.45	<b>Benefit:</b> 75% = \$2412.35	
	RUPTURED SUI (Assist.)	PRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)	
33151	Fee: \$3,056.05	<b>Benefit:</b> 75% = \$2292.05	
	RUPTURED INF (Anaes.) (Assist.)	FRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft	
33154	<b>Fee:</b> \$2,261.50	<b>Benefit:</b> 75% = \$1696.15	
		FRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)	
33157	Fee: \$2,521.20	<b>Benefit:</b> 75% = \$1890.90	
		FRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft ral arteries (Anaes.) (Assist.)	
33160	Fee: \$2,521.20	<b>Benefit:</b> 75% = \$1890.90	
	RUPTURED ILL	AC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)	
33163	<b>Fee:</b> \$2,139.40	<b>Benefit:</b> 75% = \$1604.55	
		EURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.)	
33166	<b>Fee:</b> \$2,139.40	<b>Benefit:</b> 75% = \$1604.55 85% = \$2054.70	
		EURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)	
33169	<b>Fee:</b> \$1,665.60	<b>Benefit:</b> 75% = \$1249.20	
	ANEURYSM OF	MAJOR ARTERY, replacement by graft, not being a service to which another item in plies (Anaes.) (Assist.)	
33172	Fee: \$1,298.80	<b>Benefit:</b> 75% = \$974.10	
	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.)		
33175	<b>Fee:</b> \$1,196.95	<b>Benefit:</b> 75% = \$897.75	
	RUPTURED AN grafting (Anaes.)	EURYSM IN THE NECK, ligation, suture closure or excision of, without bypass (Assist.)	
33178	Fee: \$1,522.15	<b>Benefit:</b> 75% = \$1141.65	
		RA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, rafting (Anaes.) (Assist.)	
33181	<b>Fee:</b> \$1,861.00	<b>Benefit:</b> 75% = \$1395.75	

T8. SUF	RGICAL OPERATION	ONS 3	. VASCULAR
		ENDARTERECTOMY AND ARTERIAL PATCH	
	ARTERY OR AR	RTERIES OF NECK, endarterectomy of, including closure by suture (wh f 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes	iere s.) (Assist.)
33500	Fee: \$1,153.55	<b>Benefit:</b> 75% = \$865.20	
	INNOMINATE ( (Assist.)	DR SUBCLAVIAN ARTERY, endarterectomy of, including closure by s	uture (Anaes.)
33506	Fee: \$1,291.25	<b>Benefit:</b> 75% = \$968.45	
		RTERECTOMY, including closure by suture, not being a service associate on the aorta (Anaes.) (Assist.)	ted with
33509	<b>Fee:</b> \$1,444.10	<b>Benefit:</b> 75% = \$1083.10	
		ENDARTERECTOMY (1 or both iliac arteries), including closure by sut I with a service to which item 33515 applies (Anaes.) (Assist.)	ure not being a
33512	Fee: \$1,604.55	<b>Benefit:</b> 75% = \$1203.45	
	FEMORAL END	RAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ARTERECTOMY, including closure by suture, not being a service associtem 33512 applies (Anaes.) (Assist.)	
33515	Fee: \$1,765.05	<b>Benefit:</b> 75% = \$1323.80	
		ERECTOMY, including closure by suture, not being a service associated iliac artery (Anaes.) (Assist.)	l with another
33518	Fee: \$1,291.25	<b>Benefit:</b> 75% = \$968.45 85% = \$1206.55	
	ILIO-FEMORAL	ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (A	Assist.)
33521	Fee: \$1,398.10	<b>Benefit:</b> 75% = \$1048.60	
		Y, endarterectomy of (Anaes.) (Assist.)	
33524	<b>Fee:</b> \$1,650.30	<b>Benefit:</b> 75% = \$1237.75	
	. ,	IES (both), endarterectomy of (Anaes.) (Assist.)	
33527	<b>Fee:</b> \$1,917.55	<b>Benefit:</b> 75% = \$1438.20	
33321		UPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assis	st.)
22520		<b>Benefit:</b> 75% = \$1237.75	,
33530	Fee: \$1,650.30	SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Ass	sist )
22522			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
33533		Benefit: 75% = \$1438.20  ENTERIC ARTERY, endarterectomy of, not being a service associated vitam in this Sub-group analise (Apace) (Assist)	with a service
		item in this Sub-group applies (Anaes.) (Assist.)	
33536	Fee: \$1,367.65	<b>Benefit:</b> 75% = \$1025.75	
	ARTERY OF EX	TREMITIES, endarterectomy of, including closure by suture (Anaes.) (A	Assist.)
33539	Fee: \$985.55	<b>Benefit:</b> 75% = \$739.20	
33542	EXTENDED DE	EP FEMORAL ENDARTERECTOMY where the endarterectomy is at le	east 7cms long

T8. SUF	RGICAL OPERATIONS 3	. VASCULAR
	(Anaes.) (Assist.)	
	<b>Fee:</b> \$1,405.80 <b>Benefit:</b> 75% = \$1054.35	
	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material wheless than 3cm long (Anaes.) (Assist.)	nere patch is
33545	(See para TN.8.36 of explanatory notes to this Category) <b>Fee:</b> \$278.05 <b>Benefit:</b> 75% = \$208.55	
	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material wl 3cm long or greater (Anaes.) (Assist.)	nere patch is
33548	(See para TN.8.36 of explanatory notes to this Category) <b>Fee:</b> \$565.50 <b>Benefit:</b> 75% = \$424.15	
	VEIN, harvesting of from leg or arm for patch when not performed through same incision (Anaes.) (Assist.)	as operation
33551	(See para TN.8.36 of explanatory notes to this Category) <b>Fee:</b> \$278.05 <b>Benefit:</b> 75% = \$208.55	
	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the sit anastomosis - each site (Anaes.) (Assist.)	e for
33554	<b>Fee:</b> \$276.75 <b>Benefit:</b> 75% = \$207.60	
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA	
	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.)	
33800	<b>Fee:</b> \$1,199.50 <b>Benefit:</b> 75% = \$899.65 85% = \$1114.80	
	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypas trunk (Anaes.) (Assist.)	s graft of
33803	<b>Fee:</b> \$1,146.10 <b>Benefit:</b> 75% = \$859.60	
	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) fr or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, claimed once per extremity, regardless of the number of incisions required to access the ar graft (Anaes.) (Assist.)	item to be
33806	<b>Fee:</b> \$825.15 <b>Benefit:</b> 75% = \$618.90 85% = \$740.45	
	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the fen (Anaes.) (Assist.)	noral vein
33810	<b>Fee:</b> \$601.95 <b>Benefit:</b> 75% = \$451.50 85% = \$517.25	
	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes	s.) (Assist.)
33811	<b>Fee:</b> \$1,792.00 <b>Benefit:</b> 75% = \$1344.00	
	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.)	
33812	<b>Fee:</b> \$947.35 <b>Benefit:</b> 75% = \$710.55 85% = \$862.65	
	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of c lateral suture (Anaes.) (Assist.)	ontinuity, by
33815	<b>Fee:</b> \$871.00 <b>Benefit:</b> 75% = \$653.25	
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of co	ontinuity, by

T8. SUF	RGICAL OPERATIO	NS 3. VASCULA		
	direct anastomosis	Anaes.) (Assist.)		
	<b>Fee:</b> \$1,016.15	<b>Benefit:</b> 75% = \$762.15		
	MAJOR ARTERY	OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by f synthetic material or vein (Anaes.) (Assist.)		
33821	<b>Fee:</b> \$1,161.30	<b>Benefit:</b> 75% = \$871.00		
	MAJOR ARTERY suture (Anaes.) (As	OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral sist.)		
33824	<b>Fee:</b> \$1,107.80	<b>Benefit:</b> 75% = \$830.85		
	MAJOR ARTERY anastomosis (Anaes	OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct (a) (Assist.)		
33827	Fee: \$1,298.80	<b>Benefit:</b> 75% = \$974.10		
		OR VEIN OF NECK, repair of wound of, with restoration of continuity, by f synthetic material or vein (Anaes.) (Assist.)		
33830	<b>Fee:</b> \$1,489.75	<b>Benefit:</b> 75% = \$1117.35		
	MAJOR ARTERY lateral suture (Anae	OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by s.) (Assist.)		
33833	<b>Fee:</b> \$1,352.45	<b>Benefit:</b> 75% = \$1014.35		
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.)			
33836	<b>Fee:</b> \$1,612.15	<b>Benefit:</b> 75% = \$1209.15		
	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.)			
33839	<b>Fee:</b> \$1,887.10	<b>Benefit:</b> 75% = \$1415.35		
	ARTERY OF NEC (Anaes.) (Assist.)	K, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery		
33842	<b>Fee:</b> \$932.10	<b>Benefit:</b> 75% = \$699.10		
		or control of post operative bleeding or thrombosis after intra-abdominal vascular o other procedure is performed (Anaes.) (Assist.)		
33845	<b>Fee:</b> \$649.45	<b>Benefit:</b> 75% = \$487.10		
		peration on, for control of bleeding or thrombosis after vascular procedure, where neerformed (Anaes.) (Assist.)		
33848	Fee: \$649.45	<b>Benefit:</b> 75% = \$487.10		
		ON, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS		
		OF NECK, elective ligation or exploration of, not being a service associated with procedure (Anaes.) (Assist.)		
34100	Fee: \$718.30	<b>Benefit:</b> 75% = \$538.75		
34103	Great artery (aorta	or pulmonary artery) or great vein (superior or inferior vena cava), ligation or ediate branches or tributaries, or ligation or exploration of the subclavian, axillary,		

T8. SUI	RGICAL OPERATION	DNS 3. VASCULAR
	32520, 32522, 325	opliteal arteries or veins, if the service is not associated with item 32508, 32511, 23, 32526, 32528 or 32529 - for a maximum of 2 services provided to the same e occasion (H) (Anaes.) (Assist.)
	<b>Fee:</b> \$420.15	<b>Benefit:</b> 75% = \$315.15
	exploration of, not	(N (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or being a service associated with any other vascular procedure except those services to 3, 32511, 32514 or 32517 apply (Anaes.) (Assist.)
34106	Fee: \$296.35 Extended Medica	<b>Benefit:</b> 75% = \$222.30 85% = \$251.90 <b>re Safety Net Cap:</b> \$237.10
	TEMPORAL ART	TERY, biopsy of (Anaes.) (Assist.)
34109	Fee: \$343.75	<b>Benefit:</b> 75% = \$257.85 85% = \$292.20
	ARTERIO-VENO	US FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.)
34112	Fee: \$871.00	<b>Benefit:</b> 75% = \$653.25
	ARTERIO-VENO	US FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.)
34115	Fee: \$985.55	<b>Benefit:</b> 75% = \$739.20
	ARTERIO-VENO	US FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.)
34118	<b>Fee:</b> \$1,405.80	<b>Benefit:</b> 75% = \$1054.35 85% = \$1321.10
	ARTERIO-VENO continuity (Anaes.	US FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of (Assist.)
34121	Fee: \$1,123.05	<b>Benefit:</b> 75% = \$842.30
	ARTERIO-VENO (Anaes.) (Assist.)	US FISTULA OF THE NECK, dissection and repair of, with restoration of continuity
34124	Fee: \$1,230.15	<b>Benefit:</b> 75% = \$922.65
	ARTERIO-VENO continuity (Anaes.	US FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of (Assist.)
34127	Fee: \$1,612.15	<b>Benefit:</b> 75% = \$1209.15
	SURGICALLY C (Assist.)	REATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.)
34130	Fee: \$504.25	<b>Benefit:</b> 75% = \$378.20 85% = \$428.65
	SCALENOTOMY	(Anaes.) (Assist.)
34133	Fee: \$565.50	<b>Benefit:</b> 75% = \$424.15
	FIRST RIB, resect	ion of portion of (Anaes.) (Assist.)
34136	Fee: \$909.05	<b>Benefit:</b> 75% = \$681.80
		removal of, or other operation for removal of thoracic outlet compression, not being a nother item in this Sub-group applies (Anaes.) (Assist.)
34139	Fee: \$909.05	<b>Benefit:</b> 75% = \$681.80
34142	COELIAC ARTE	RY, decompression of, for coeliac artery compression syndrome, as an independent

T8. SUF	RGICAL OPERATI	ONS 3. VASCULAR
	procedure (Anaes	.) (Assist.)
	<b>Fee:</b> \$1,123.05	<b>Benefit:</b> 75% = \$842.30
		TERY, exploration of, for popliteal entrapment, with or without division of fibrous (Anaes.) (Assist.)
34145	<b>Fee:</b> \$817.50	<b>Benefit:</b> 75% = \$613.15
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal d arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.)
34148	<b>Fee:</b> \$1,459.30	<b>Benefit:</b> 75% = \$1094.50
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal d arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)
34151	Fee: \$1,994.05	<b>Benefit:</b> 75% = \$1495.55
		AROTID ASSOCIATED TUMOUR, resection of, with or without repair or ortion of internal or common carotid arteries (Anaes.) (Assist.)
34154	<b>Fee:</b> \$2,376.15	<b>Benefit:</b> 75% = \$1782.15 85% = \$2291.45
	NECK, excision of	of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)
34157	<b>Fee:</b> \$1,207.20	<b>Benefit:</b> 75% = \$905.40
	AORTO-DUODE (Assist.)	ENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.)
34160	<b>Fee:</b> \$2,261.50	<b>Benefit:</b> 75% = \$1696.15
	AORTO-DUODE (Anaes.) (Assist.)	ENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum
34163	Fee: \$2,903.25	<b>Benefit:</b> 75% = \$2177.45
		ENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and grafting (Anaes.) (Assist.)
34166	Fee: \$2,903.25	<b>Benefit:</b> 75% = \$2177.45
	INFECTED BYP (Assist.)	ASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.)
34169	Fee: \$1,612.15	<b>Benefit:</b> 75% = \$1209.15
	INFECTED AXII arteries (Anaes.) (	LLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of (Assist.)
34172	<b>Fee:</b> \$1,314.10	<b>Benefit:</b> 75% = \$985.60
	INFECTED BYP (Anaes.) (Assist.)	ASS GRAFT FROM EXTREMITIES, excision of including closure of arteries
34175	<b>Fee:</b> \$1,207.20	<b>Benefit:</b> 75% = \$905.40
		OPERATIONS FOR VASCULAR ACCESS
	ARTERIOVENO	US SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.)
34500	Fee: \$313.35	<b>Benefit:</b> 75% = \$235.05 85% = \$266.35

T8. SUF	RGICAL OPERATI	ONS	3. VASCULAR
		OUS ANASTOMOSIS OF UPPER OR LOWE I operation (Anaes.) (Assist.)	R LIMB, in conjunction with another
34503	Fee: \$420.15	<b>Benefit:</b> 75% = \$315.15	
	ARTERIOVENO	OUS SHUNT, EXTERNAL, removal of (Anae	s.) (Assist.)
34506	Fee: \$213.80	<b>Benefit:</b> 75% = \$160.35	
		OUS ANASTOMOSIS OF UPPER OR LOWEr arterial operation (Anaes.) (Assist.)	R LIMB, not in conjunction with
34509	Fee: \$993.20	<b>Benefit:</b> 75% = \$744.90	
	ARTERIOVENO	OUS ACCESS DEVICE, insertion of (Anaes.)	(Assist.)
34512	Fee: \$1,092.60	<b>Benefit:</b> 75% = \$819.45	
	ARTERIOVENO	OUS ACCESS DEVICE, thrombectomy of (Ar	naes.) (Assist.)
34515	Fee: \$779.25	<b>Benefit:</b> 75% = \$584.45	
		ARTERIOVENOUS FISTULA OR PROSTHE tion of (Anaes.) (Assist.)	TTIC ARTERIOVENOUS ACCESS
34518	Fee: \$1,306.30	<b>Benefit:</b> 75% = \$979.75	
		IINAL ARTERY OR VEIN, cannulation of, following aftercare) (Anaes.) (Assist.)	or infusion chemotherapy, by open
34521	(See para TN.8.4 o <b>Fee:</b> \$802.60	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$601.95	
		NNULATION for infusion chemotherapy by on a pplies (excluding after-care) (Anaes.) (Assistant)	
34524	(See para TN.8.4 o <b>Fee:</b> \$420.15	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$315.15	
	access port as wi	N CATHETERISATION by open technique, u th central venous line catheter or other chemot aneous central vein catheterization, on a perso	herapy delivery device, including any
34527	Fee: \$560.45	<b>Benefit:</b> 75% = \$420.35 85% = \$476.40	
	pump or access p	N CATHETERISATION by percutaneous tech cort as with central venous line catheter or othe of age or over (Anaes.)	
34528	Fee: \$276.75	<b>Benefit:</b> 75% = \$207.60 85% = \$235.25	
	access port as wi	N CATHETERISATION by open technique, u th central venous line catheter or other chemot aneous central vein catheterization, on a perso	herapy delivery device, including any
34529	Fee: \$728.55	<b>Benefit:</b> 75% = \$546.45 85% = \$643.85	
		OUS LINE, OR OTHER CHEMOTHERAPY operating theatre of a hospital on a person 10 y	
34530	Fee: \$207.50	<b>Benefit:</b> 75% = \$155.65 85% = \$176.40	
34533	ISOLATED LIM	B PERFUSION, including cannulation of arte	ry and vein at commencement of

T8. SUR	RGICAL OPERATION	NS 3. VASCULAR
		l perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at edure (excluding aftercare) (Anaes.) (Assist.)
	<b>Fee:</b> \$1,260.50	<b>Benefit:</b> 75% = \$945.40 85% = \$1175.80
	pump or access po	CATHETERISATION by percutaneous technique, using subcutaneous tunnel with rt as with central venous line catheter or other chemotherapy delivery device, on a ars of age (Anaes.)
34534	Fee: \$359.75	<b>Benefit:</b> 75% = \$269.85 85% = \$305.80
		CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.)
34538	Fee: \$276.75	<b>Benefit:</b> 75% = \$207.60 85% = \$235.25
	TUNNELLED CO (Anaes.)	FFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure
34539	<b>Fee:</b> \$207.50	<b>Benefit:</b> 75% = \$155.65 85% = \$176.40
		US LINE, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical perating theatre of a hospital, on a person under 10 years of age (Anaes.)
34540	Fee: \$269.75	<b>Benefit:</b> 75% = \$202.35 85% = \$229.30
		COMPLEX VENOUS OPERATIONS
	INFERIOR VEN	CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.)
34800	<b>Fee:</b> \$825.15	<b>Benefit:</b> 75% = \$618.90 85% = \$740.45
	INFERIOR VEN	CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.)
34803	Fee: \$1,818.50	<b>Benefit:</b> 75% = \$1363.90
	CROSS LEG BY	ASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.)
34806	<b>Fee:</b> \$985.55	<b>Benefit:</b> 75% = \$739.20
3 1000		IN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.)
34809	Fee: \$985.55	<b>Benefit:</b> 75% = \$739.20
		SIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a with a service to which item 34806 or 34809 applies (Anaes.) (Assist.)
34812	<b>Fee:</b> \$1,191.80	<b>Benefit:</b> 75% = \$893.85
	VEIN STENOSIS (Anaes.) (Assist.)	patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material
34815	(See para TN.8.36 o <b>Fee:</b> \$985.55	explanatory notes to this Category) <b>Benefit:</b> 75% = \$739.20
	VENOUS VALV	, plication or repair to restore valve competency (Anaes.) (Assist.)
34818	<b>Fee:</b> \$1,084.90	<b>Benefit:</b> 75% = \$813.70
	VEIN TRANSPL	NT to restore valvular function (Anaes.) (Assist.)
34821	<b>Fee:</b> \$1,474.65	<b>Benefit:</b> 75% = \$1106.00 85% = \$1389.95

T8. SUF	RGICAL OPERAT	IONS 3. VASCULAR	
	EXTERNAL ST (Anaes.) (Assist.	ENT, application of, to restore venous valve competency to superficial vein - 1 stent	
34824	Fee: \$504.25	<b>Benefit:</b> 75% = \$378.20	
		ENTS, application of, to restore venous valve competency to superficial vein or veins - t (Anaes.) (Assist.)	
34827	<b>Fee:</b> \$611.30	<b>Benefit:</b> 75% = \$458.50	
	EXTERNAL ST (Assist.)	ENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.)	
34830	<b>Fee:</b> \$718.30	<b>Benefit:</b> 75% = \$538.75 85% = \$633.60	
	EXTERNAL ST than 1 stent) (An	ENTS, application of, to restore venous valve competency to deep vein or veins (more aes.) (Assist.)	
34833	Fee: \$932.10	<b>Benefit:</b> 75% = \$699.10	
		SYMPATHECTOMY	
	LUMBAR SYM	PATHECTOMY (Anaes.) (Assist.)	
35000	Fee: \$718.30	<b>Benefit:</b> 75% = \$538.75 85% = \$633.60	
	CERVICAL OR (Assist.)	UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.)	
35003	Fee: \$932.10	<b>Benefit:</b> 75% = \$699.10	
		UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for lete sympathectomy by any surgical approach (Anaes.) (Assist.)	
35006	Fee: \$1,168.95	<b>Benefit:</b> 75% = \$876.75	
		PATHECTOMY, where operation is following chemical sympathectomy or for lete surgical sympathectomy (Anaes.) (Assist.)	
35009	Fee: \$909.05	<b>Benefit:</b> 75% = \$681.80	
	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)		
35012	Fee: \$718.30	<b>Benefit:</b> 75% = \$538.75	
		DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE	
		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating ital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.)	
35100	Fee: \$374.45	<b>Benefit:</b> 75% = \$280.85	
		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating ital, superficial tissue only (Anaes.)	
35103	Fee: \$238.30	<b>Benefit:</b> 75% = \$178.75	
		MISCELLANEOUS VASCULAR PROCEDURES	
		RTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of cedure on an artery or vein, 1 site (Anaes.)	
35200	Fee: \$174.25	<b>Benefit:</b> 75% = \$130.70	
35202	MAJOR ARTER	RIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of	

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.)	
	<b>Fee:</b> \$830.15 <b>Benefit:</b> 75% = \$622.65	
	ENDOVASCULAR INTERVENTIONAL PROCEDURES	
	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 learn or by open exposure, excluding associated radiological services or preparation, and ex (Anaes.) (Assist.)	
35300	<b>Fee:</b> \$523.60 <b>Benefit:</b> 75% = \$392.70 85% = \$445.10	
	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visce more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excadiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	
35303	<b>Fee:</b> \$671.35 <b>Benefit:</b> 75% = \$503.55 85% = \$586.65	
	TRANSLUMINAL STENT INSERTION, 1 or more stents, including associated ballo peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated ballo services or preparation, and excluding aftercare. (Anaes.) (Assist.)	
35306	<b>Fee:</b> \$619.65 <b>Benefit:</b> 75% = \$464.75 85% = \$534.95	
	TRANSLUMINAL STENT INSERTION, 1 or more stents (not drug-eluting), with or associated balloon dilatation, for 1 carotid artery, percutaneous (not direct), with or wite embolic protection device, in patients who:	
	- meet the indications for carotid endarterectomy; and	
	<ul> <li>have medical or surgical comorbidities that would make them at high risk of period complications from carotid endarterectomy,</li> </ul>	perative
	excluding associated radiological services or preparation, and excluding aftercare (An	aes.) (Assist.)
35307	(See para TN.8.37 of explanatory notes to this Category) <b>Fee:</b> \$1,139.10 <b>Benefit:</b> 75% = \$854.35	
	TRANSLUMINAL STENT INSERTION, 1 or more stents, including associated ballovisceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutane exposure, excluding associated radiological services or preparation, and excluding after (Assist.)	ous or by open
35309	<b>Fee:</b> \$774.55 <b>Benefit:</b> 75% = \$580.95 85% = \$689.85	
	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation percutaneous or by open exposure, excluding associated radiological services or preparexcluding aftercare (Anaes.) (Assist.)	
35312	<b>Fee:</b> \$877.85 <b>Benefit:</b> 75% = \$658.40	
	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 or by open exposure, excluding associated radiological services or preparation, and ex (Anaes.) (Assist.)	
35315	<b>Fee:</b> \$877.85 <b>Benefit:</b> 75% = \$658.40	
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous apprassociated radiological services or preparation, and excluding aftercare (not being a sewith a service to which another item in Subgroup 11 of Group T1 or items 35319 or 3.	roach, excluding ervice associated

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	not being a service associated with photodynamic therapy with verteporfin	) (Anaes.) (Assist.)
	(See para TN.8.38 of explanatory notes to this Category) <b>Fee:</b> \$361.50 <b>Benefit:</b> 75% = \$271.15  85% = \$307.30	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with ad or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using per excluding associated radiological services or preparation, and excluding af associated with a service to which another item in Subgroup 11 of Group T applies and not being a service associated with photodynamic therapy with (Assist.)	cutaneous approach, tercare (not being a service 11 or items 35317 or 35320
35319	<b>Fee:</b> \$648.00 <b>Benefit:</b> 75% = \$486.00 85% = \$563.30	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with ad or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated preparation, and excluding aftercare (not being a service associated with a in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being photodynamic therapy with verteporfin) (Anaes.) (Assist.)	radiological services or service to which another item
35320	<b>Fee:</b> \$870.40 <b>Benefit:</b> 75% = \$652.80 85% = \$785.70	
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to admi arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not fibroids or varicose veins) percutaneous or by open exposure, excluding as or preparation, and excluding aftercare, not being a service associated with verteporfin (Anaes.) (Assist.)	for the treatment of uterine sociated radiological services
35321	(See para TN.8.32 of explanatory notes to this Category) <b>Fee:</b> \$826.30 <b>Benefit:</b> 75% = \$619.75 85% = \$741.60	
	ANGIOSCOPY not combined with any other procedure, excluding associal preparation, and excluding aftercare (Anaes.) (Assist.)	nted radiological services or
35324	<b>Fee:</b> \$309.85 <b>Benefit:</b> 75% = \$232.40	
	ANGIOSCOPY combined with any other procedure, excluding associated preparation, and excluding aftercare (Anaes.) (Assist.)	radiological services or
35327	<b>Fee:</b> \$415.25 <b>Benefit:</b> 75% = \$311.45	
	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by associated radiological services or preparation, and excluding aftercare (Ar	
35330	<b>Fee:</b> \$523.60 <b>Benefit:</b> 75% = \$392.70 85% = \$445.10	
	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or b including associated radiological services or preparation, and not including	
35331	<b>Fee:</b> \$601.95 <b>Benefit:</b> 75% = \$451.50	
	Retrieval of foreign body in PULMONARY ARTERY, percutaneous or by associated radiological services or preparation, and not including aftercare	open exposure, not including
	(foreign body does not include an instrument inserted for the purpose of a (Anaes.) (Assist.)	service being rendered)
35360	<b>Fee:</b> \$841.45 <b>Benefit:</b> 75% = \$631.10	

T8. SUF	RGICAL OPERATIONS 3. VASO	ULAR
	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.)	)
35361	<b>Fee:</b> \$721.65 <b>Benefit:</b> 75% = \$541.25	
	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous or by open exponot including associated radiological services or preparation, and not including aftercare	osure,
	(foreign body does not include an instrument inserted for the purpose of a service being rendered (Anaes.) (Assist.)	)
35362	<b>Fee:</b> \$601.95 <b>Benefit:</b> 75% = \$451.50	
	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, percutaneous or be 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.)	)
35363	<b>Fee:</b> \$482.25 <b>Benefit:</b> 75% = \$361.70	
	INTERVENTIONAL RADIOLOGY PROCEDURES	
	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective internal radiatio therapy of hepatic metastases which are secondary to colorectal cancer and are not suitable for res or ablation, used in combination with systemic chemotherapy using 5-fluorouracil (5FU) and leuc not being a service to which item 35317, 35319, 35320 or 35321 applies	ection
	The procedure must be performed by a specialist or consultant physician recognised in the special nuclear medicine or radiation oncology on an admitted patient in a hospital. To be claimed once in patient's lifetime only.	
35404	(See para TN.3.1, TN.8.40 of explanatory notes to this Category)  Fee: \$352.15  Benefit: 75% = \$264.15	
	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 suital 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	)
35406	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) <b>Fee:</b> \$826.30 <b>Benefit:</b> 75% = \$619.75	
35408	Catheterisation of the hepatic artery via a permanently implanted hepatic artery port to administer Spheres to embolise the microvasculature of hepatic metastases which are secondary to colorectal and are not suitable for resection or ablation, for selective internal radiation therapy used in combi with systemic chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to wh	cancer nation

T8. SUF	RGICAL OPERATIONS 3. VASCULAR
	item 35317, 35319, 35320 or 35321 applies
	excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) <b>Fee:</b> \$619.85 <b>Benefit:</b> 75% = \$464.90
	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.)
35410	(See para TN.8.34 of explanatory notes to this Category) <b>Fee:</b> \$826.30 <b>Benefit:</b> 75% = \$619.75 85% = \$741.60
	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 aftercare, including intra-operative imaging, but in association with the following preoperative diagnostic imaging items:
	- either 60009 or 60010; and
	- either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (Assist.)
35412	(See para TN.8.35 of explanatory notes to this Category) <b>Fee:</b> \$2,903.25 <b>Benefit:</b> 75% = \$2177.45 85% = \$2818.55
	Mechanical thrombectomy, in a patient with a diagnosis of acute ischaemic stroke caused by occlusion of a large vessel of the anterior cerebral circulation, including intra-operative imaging and aftercare, if:
	(a) the diagnosis is confirmed by an appropriate imaging modality such as computed tomography, magnetic resonance imaging or angiography; and
	(b) the service is performed by a specialist or consultant physician with appropriate training that is recognised by the Conjoint Committee for Recognition of Training in Interventional Neuroradiology; and
	(c) the service is provided in an eligible stroke centre.
	For any particular patient - applicable once per presentation by the patient at an eligible stroke centre, regardless of the number of times mechanical thrombectomy is attempted during that presentation (Anaes.) (Assist.)
35414	(See para TR.8.1 of explanatory notes to this Category) <b>Fee:</b> \$3,556.00 <b>Benefit:</b> 75% = \$2667.00
T8. SUF	RGICAL OPERATIONS 4. GYNAECOLOGICAL
	Group T8. Surgical Operations
	Subgroup 4. Gynaecological
	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)
35500	<b>Fee:</b> \$82.60 <b>Benefit:</b> 75% = \$61.95 85% = \$70.25
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

T8. SUF	RGICAL OPERAT	IONS 4. GYNAECOLOGICAL
	service to which	another item in this Group applies (Anaes.)
	Fee: \$81.45	<b>Benefit:</b> 75% = \$61.10 85% = \$69.25
		traceptive device, introduction of, if the service is not associated with a service to which his Group applies (other than a service mentioned in item 30062) (Anaes.)
35503	Fee: \$54.40	<b>Benefit:</b> 75% = \$40.80 85% = \$46.25
		E CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL , not being a service associated with a service to which another item in this Group
35506	Fee: \$54.55	<b>Benefit:</b> 75% = \$40.95 85% = \$46.40
	nerve block (exc	AGINAL WARTS, removal of under general anaesthesia, or under regional or field luding pudendal block) requiring admission to a hospital, where the time taken is less 45 minutes - not being a service associated with a service to which item 32177 or 32180
35507	Fee: \$177.25	<b>Benefit:</b> 75% = \$132.95 85% = \$150.70
	nerve block (exc	AGINAL WARTS, removal of under general anaesthesia, or under regional or field luding pudendal block) requiring admission to a hospital, where the time taken is ninutes - not being a service associated with a service to which item 32177 or 32180 (Assist.)
35508	Fee: \$261.05	<b>Benefit:</b> 75% = \$195.80 85% = \$221.90
	HYMENECTO	MY (Anaes.)
35509	Fee: \$90.90	<b>Benefit:</b> 75% = \$68.20 85% = \$77.30
	BARTHOLIN'S	CYST, excision of (Anaes.)
35513	Fee: \$225.25	<b>Benefit:</b> 75% = \$168.95 85% = \$191.50
	BARTHOLIN'S	CYST OR GLAND, marsupialisation of (Anaes.)
35517	Fee: \$148.35	<b>Benefit:</b> 75% = \$111.30 85% = \$126.10
	least 2cm in dian	T ASPIRATION, for cysts of at least 4cm in diameter in a premenopausal person and at neter in a postmenopausal person, by abdominal or vaginal route, using interventional nes and not associated with services provided for assisted reproductive techniques
35518	(See para TN.4.11 <b>Fee:</b> \$211.20	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$158.40 85% = \$179.55
	BARTHOLIN'S ABSCESS, incision of (Anaes.)	
35520	Fee: \$59.25	<b>Benefit:</b> 75% = \$44.45 85% = \$50.40
	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.)	
35523	Fee: \$59.25	<b>Benefit:</b> 75% = \$44.45 85% = \$50.40
	URETHRAL CA	ARUNCLE, excision of (Anaes.)
35527	Fee: \$148.35	<b>Benefit:</b> 75% = \$111.30 85% = \$126.10
35530	CLITORIS, amp	utation of, where medically indicated (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	TIONS	4. GYNAECOLOGICAL
	Fee: \$274.15	<b>Benefit:</b> 75% = \$205.65	
	Vulvoplasty or l	abioplasty, for repair of:	
	(a) female genita	al mutilation; or	
	(b) an anomaly a	associated with a major conger	nital anomaly of the uro-gynaecological tract
	other than a serv 43882 applies (A		o which item 35536, 37836, 37050, 37842, 37851 or
35533	(See para TN.8.12 <b>Fee:</b> \$355.45	3 of explanatory notes to this Cat <b>Benefit:</b> 75% = \$266.60	egory)
	of the specialist' if the patient's la	s specialty, for a structural abn	B years or more, performed by a specialist in the practice ormality that is causing significant functional impairment, below the vaginal introitus while the patient is in a
35534	(See para TN.8.12 <b>Fee:</b> \$355.45	3 of explanatory notes to this Cat <b>Benefit:</b> 75% = \$266.60	egory)
	VULVA, wide l (Anaes.) (Assist		ignancy or hemivulvectomy, 1 or both procedures
35536	Fee: \$354.05	<b>Benefit:</b> 75% = \$265.55	85% = \$300.95
	neoplastic chang		ER THERAPY for previously confirmed intraepithelial , urethra or anal canal, including any associated
35539	Fee: \$277.30	<b>Benefit:</b> 75% = \$208.00	85% = \$235.75
	neoplastic chan		ER THERAPY for previously confirmed intraepithelial a, urethra or anal canal, including any associated Assist.)
35542	Fee: \$324.70	<b>Benefit:</b> 75% = \$243.55	85% = \$276.00
	COLPOSCOPIO by other method		ER THERAPY for condylomata, unsuccessfully treated
35545	Fee: \$186.55	<b>Benefit:</b> 75% = \$139.95	85% = \$158.60
	VULVECTOM	Y, radical, for malignancy (An	aes.) (Assist.)
35548	Fee: \$847.40	<b>Benefit:</b> 75% = \$635.55	
	PELVIC LYMP	H NODES, excision of (radica	ıl) (Anaes.) (Assist.)
35551	Fee: \$694.85	<b>Benefit:</b> 75% = \$521.15	
	VAGINA, DILA (Anaes.)	ATATION OF, as an independent	ent procedure including any associated consultation
35554	Fee: \$44.20	<b>Benefit:</b> 75% = \$33.15 8	5% = \$37.60
		val of simple tumour (including	
35557	<b>Fee:</b> \$217.95	<b>Benefit:</b> 75% = \$163.50	85% = \$185.30
35560		al or complete removal of (Ana	

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL	
	Fee: \$694.85	<b>Benefit:</b> 75% = \$521.15		
	VAGINECTOM	Y, radical, for proven invasive r	nalignancy - 1 surgeon (Anaes.) (Assist.)	
35561	Fee: \$1,401.55	<b>Benefit:</b> 75% = \$1051.20		
		Y, radical, for proven invasive r re) (Anaes.) (Assist.)	nalignancy, conjoint surgery - abdominal surgeon	
35562	<b>Fee:</b> \$1,150.70	<b>Benefit:</b> 75% = \$863.05		
	VAGINECTOM	Y, radical, for proven invasive r	nalignancy, conjoint surgery - perineal surgeon (Assist.)	
35564	<b>Fee:</b> \$531.20	<b>Benefit:</b> 75% = \$398.40		
	VAGINAL RECO (Assist.)	ONSTRUCTION for congenital	absence, gynatresia or urogenital sinus (Anaes.)	
35565	Fee: \$694.85	<b>Benefit:</b> 75% = \$521.15		
	VAGINAL SEPT	UM, excision of, for correction	of double vagina (Anaes.) (Assist.)	
35566	Fee: \$403.60	<b>Benefit:</b> 75% = \$302.70		
	SACROSPINOU (Assist.)	S COLPOPEXY FOR MANAC	EMENT OF UPPER VAGINAL PROLAPSE (Anaes.)	
35568	Fee: \$634.60	<b>Benefit:</b> 75% = \$475.95		
	PLASTIC REPA	IR TO ENLARGE VAGINAL	DRIFICE (Anaes.)	
35569	Fee: \$163.40	<b>Benefit:</b> 75% = \$122.55		
	Anterior vaginal compartment repair by vaginal approach for pelvic organ prolapse (involving repair of urethrocele and cystocele), using native tissue without graft, other than a service associated with a service to which item 35573, 35577 or 35578 applies.			
	(Anaes.) (Assist	.)		
35570	Fee: \$562.70	<b>Benefit:</b> 75% = \$422.05		
	Posterior vaginal one or more of th	1 1 0	approach for pelvic organ prolapse involving repair of	
	(a) perineum;			
	(b) rectocoele;			
	(c) enterocoele;			
	using native tissu 35577 or 35578 a		vice associated with a service to which item 35573,	
	(Anaes.) (Assist	.)		
35571	Fee: \$562.70	<b>Benefit:</b> 75% = \$422.05		
	COLPOTOMY 1	not being a service to which and	ther item in this Group applies (Anaes.)	
35572	Fee: \$125.80	<b>Benefit:</b> 75% = \$94.35		
35573	Anterior and post	erior vaginal compartment repa	ir by vaginal approach for pelvic organ prolapse fects), using native tissue without graft, other than a	

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	service associated with a service to which item 35577 or 35578 applies.	
	(Anaes.) (Assist.)	
	<b>Fee:</b> \$844.20 <b>Benefit:</b> 75% = \$633.15	
	Manchester (Donald Fothergill) operation for pelvic organ prolapse (incluanterior and posterior native tissue vaginal wall repairs without graft).	udes cervical amputation,
	(Anaes.) (Assist.)	
35577	<b>Fee:</b> \$685.30 <b>Benefit:</b> 75% = \$514.00	
	LE FORT OPERATION for genital prolapse, not being a service associat another item in this Subgroup applies (Anaes.) (Assist.)	ted with a service to which
35578	<b>Fee:</b> \$685.30 <b>Benefit:</b> 75% = \$514.00	
	Vaginal procedure for excision of graft material in symptomatic patients complications, including graft related pain or discharge and bleeding rela 2cm <sup>2</sup> in its maximum area, either singly or in multiple pieces, other than service to which item 35582 or 35585 applies.	ted to graft exposure, less than
	(Anaes.) (Assist.)	
35581	(See para TN.8.140 of explanatory notes to this Category) <b>Fee:</b> \$562.70 <b>Benefit:</b> 75% = \$422.05	
	Vaginal procedure for excision of graft material in symptomatic patients complications, including graft related pain or discharge and bleeding rela 2cm <sup>2</sup> in its maximum area, either singly or in multiple pieces, other than service to which item 35581 or 35585 applies.	ted to graft exposure, more than
	(Anaes.) (Assist.)	
35582	(See para TN.8.140 of explanatory notes to this Category) <b>Fee:</b> \$844.20 <b>Benefit:</b> 75% = \$633.15	
	Abdominal procedure either open, laparoscopic or robotic, for removal of symptomatic with graft related complications, including graft related pair related to graft exposure or where the graft has penetrated adjacent organ urethra) or bowel, including retroperitoneal dissection and mobilisation of than a service associated with a service to which item 35581 or 35582 appears to the control of t	n or discharge and bleeding s such as the bladder (including of bladder and/or bowel, other
	(Anaes.) (Assist.)	
35585	<b>Fee:</b> \$1,496.75 <b>Benefit:</b> 75% = \$1122.60	
	LAPAROSCOPIC OR ABDOMINAL PELVIC FLOOR REPAIR INCO FIXATION OF THE UTEROSACRAL AND CARDINAL LIGAMENT PUBOCERVICAL FASCIA for symptomatic upper vaginal vault prolaps	S TO RECTOVAGINAL AND
35595	<b>Fee:</b> \$1,173.50 <b>Benefit:</b> 75% = \$880.15	
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY	TRACTS, repair of, not being

T8. SUF	URGICAL OPERATIONS		4. GYNAECOLOGICAL
	a service to which	item 37029, 37333 or 37336 applies (Anaes.) (Assist.	)
	Fee: \$694.85	<b>Benefit:</b> 75% = \$521.15	
	SACRAL COLPO	OPEXY, laparoscopic or open procedure where graft or opentment and to sacrum for correction of symptomatic	
35597	<b>Fee:</b> \$1,496.75	<b>Benefit:</b> 75% = \$1122.60	
		TINENCE, sling operation for, with or without mesh o service to which item 30405 applies (Anaes.) (Assist.)	r tape, not being a service
35599	Fee: \$685.30	<b>Benefit:</b> 75% = \$514.00	
	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.)		
35602	Fee: \$685.30	<b>Benefit:</b> 75% = \$514.00	
	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.)		
35605	Fee: \$371.80	<b>Benefit:</b> 75% = \$278.85 85% = \$316.05	
		sation (other than by chemical means), ionisation, diath of cervix (Anaes.)	nermy or biopsy of, with or
35608	Fee: \$65.00	<b>Benefit:</b> 75% = \$48.75 85% = \$55.25	
		l of polyp or polypi, with or without dilatation of cervi which item 35608 applies (Anaes.)	x, not being a service associated
35611	Fee: \$65.00	<b>Benefit:</b> 75% = \$48.75 85% = \$55.25	
	CERVIX, RESID	UAL STUMP, removal of, by abdominal approach (Ar	naes.) (Assist.)
35612	Fee: \$514.10	<b>Benefit:</b> 75% = \$385.60 85% = \$437.00	
	CERVIX, RESID	UAL STUMP, removal of, by vaginal approach (Anae	s.) (Assist.)
35613	<b>Fee:</b> \$411.30	<b>Benefit:</b> 75% = \$308.50	
	EXAMINATION abnormal cervical	OF LOWER TRACT by a Hinselmanntype colposcop smear screen result or a history of maternal ingestion ious signs of cancer, has been referred by another medi	of oestrogen or where a patient,
35614	(See para TN.8.42 o <b>Fee:</b> \$64.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$48.70 85% = \$55.20	
	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies		nich item 35614 applies
35615	Fee: \$54.55	<b>Benefit:</b> 75% = \$40.95 85% = \$46.40	
	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.)		
35616	Fee: \$456.80	<b>Benefit:</b> 75% = \$342.60	
35618	CERVIX, cone bi	opsy, amputation or repair of, other than a service to w	which item 35577 or 35578

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL
	applies (Anaes.)		
	Fee: \$221.50	<b>Benefit:</b> 75% = \$166.15 85% = \$188.30	
		BIOPSY where malignancy is suspected in publeeding (Anaes.)	patients with abnormal uterine bleeding or
35620	Fee: \$54.20	<b>Benefit:</b> 75% = \$40.65 85% = \$46.10	
	including any hys	A, endoscopic ablation of, by laser or diathern steroscopy performed on the same day, with of with a service to which item 30390 applies (	r without uterine curettage, not being a
35622	Fee: \$612.10	<b>Benefit:</b> 75% = \$459.10	
		PIC RESECTION of myoma, or myoma and uwed by endometrial ablation by laser or diather	
35623	Fee: \$832.35	<b>Benefit:</b> 75% = \$624.30	
	where the patient	Y, including biopsy, performed by a specialistic is referred to him or her for the investigation naesthetic), not being a service associated with	of suspected intrauterine pathology (with
35626	(See para TN.8.43 <b>Fee:</b> \$84.10	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$63.10 85% = \$71.50	
		PY with dilatation of the cervix performed in t sociated with a service to which item 35626 of	
35627	Fee: \$108.85	<b>Benefit:</b> 75% = \$81.65	
		Y, with endometrial biopsy, performed in the ed with a service to which item 35626 or 3562	
35630	Fee: \$185.95	<b>Benefit:</b> 75% = \$139.50	
		PY with uterine adhesiolysis or polypectomy of e for sterilisation) or removal of IUD which c	
35633	Fee: \$221.50	<b>Benefit:</b> 75% = \$166.15 85% = \$188.30	
	HYSTEROSCOF diathermy (Anaes	IC RESECTION of uterine septum followed s.)	by endometrial ablation by laser or
35634	Fee: \$696.65	<b>Benefit:</b> 75% = \$522.50 85% = \$611.95	
	HYSTEROSCOF	Y involving resection of the uterine septum (	Anaes.)
35635	Fee: \$304.25	<b>Benefit:</b> 75% = \$228.20	
	HYSTEROSCOF both are performe	Y, involving resection of myoma, or resection ed) (Anaes.)	n of myoma and uterine septum (where
35636	Fee: \$439.95	<b>Benefit:</b> 75% = \$330.00	
35637	of adhesions or si	r, involving puncture of cysts, diathermy of en milar procedure - 1 or more procedures with any other laparoscopic procedure or hysterectory.	or without biopsy - not being a service

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	(See para TN.1.4 of explanatory notes to this Category) <b>Fee:</b> \$413.15 <b>Benefit:</b> 75% = \$309.90	
	COMPLICATED OPERATIVE LAPAROSCOPY, including use of lof the following procedures; oophorectomy, ovarian cystectomy, myo salpingostomy, ablation of moderate or severe endometriosis requiring or division of utero-sacral ligaments for significant dysmenorrhoea - 1 any other intraperitoneal or retroperitoneal procedure except item 303	omectomy, salpingectomy or g more than 1 hours operating time, not being a service associated with
35638	<b>Fee:</b> \$722.90 <b>Benefit:</b> 75% = \$542.20	
	UTERUS, CURETTAGE OF, with or without dilatation (including cumiscarriage) under general anaesthesia, or under epidural or spinal (in procedures to which item 35626, 35627 or 35630 applies, if performe	ntrathecal) nerve block, including
35640	(See para TN.8.44 of explanatory notes to this Category) <b>Fee:</b> \$185.95 <b>Benefit:</b> 75% = \$139.50	
	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION following procedures, resection of the pelvic side wall including disset tissue from the ureter, resection of the Pouch of Douglas, resection of than 2 cms in diameter, dissection of bowel from uterus from the level above: where the operating time exceeds 90 minutes (Anaes.) (Assist.	ection of endometriosis or scar an ovarian endometrioma greater l of the endocervical junction or
35641	<b>Fee:</b> \$1,262.55 <b>Benefit:</b> 75% = \$946.95	
	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS CURETTAGE other than a service to which item 35640 applies, inclu 35626, 35627 or 35630 applies, if performed (Anaes.)	
35643	<b>Fee:</b> \$221.50 <b>Benefit:</b> 75% = \$166.15 85% = \$188.30	
	CERVIX, electrocoagulation diathermy with colposcopy, for previous neoplastic changes of the cervix, including any local anaesthesia and lassociated with a service to which item 35640 or 35647 applies (Anae	biopsies, other than a service
35644	(See para TN.8.45 of explanatory notes to this Category) <b>Fee:</b> \$206.90 <b>Benefit:</b> 75% = \$155.20 85% = \$175.90	
	CERVIX, electrocoagulation diathermy with colposcopy, for previous neoplastic changes of the cervix, including any local anaesthesia and lablative therapy of additional areas of intraepithelial change in 1 or m or anus, not being a service associated with a service to which item 35	biopsies, in conjunction with ore sites of vagina, vulva, urethra
35645	(See para TN.8.45 of explanatory notes to this Category) <b>Fee:</b> \$323.80 <b>Benefit:</b> 75% = \$242.85 85% = \$275.25	
	CERVIX, colposcopy with radical diathermy of, with or without cerviconfirmed intraepithelial neoplastic changes of the cervix (Anaes.)	ical biopsy, for previously
35646	(See para TN.8.45 of explanatory notes to this Category) <b>Fee:</b> \$206.90 <b>Benefit:</b> 75% = \$155.20 85% = \$175.90	
	CERVIX, large loop excision of transformation zone together with co- intraepithelial neoplastic changes of the cervix, including any local an- service associated with a service to which item 35644 applies (Anaes.	naesthesia and biopsies, not being a
35647	(See para TN.8.45 of explanatory notes to this Category) <b>Fee:</b> \$206.90 <b>Benefit:</b> 75% = \$155.20 85% = \$175.90	
35648	CERVIX, large loop excision diathermy for previously confirmed into	raepithelial neoplastic changes of

T8. SUF	GICAL OPERATIONS		4. GYNAECOLOGICAL
	additional areas of intraepithelia	anaesthesia and biopsies, in conjunct al change of 1 or more sites of vagin the to which item 35645 applies (Anae	a, vulva, urethra or anus, not being a
	(See para TN.8.45 of explanatory n <b>Fee:</b> \$323.80 <b>Benefit:</b> 7.	notes to this Category) 75% = \$242.85 85% = \$275.25	
	HYSTEROTOMY or UTERIN	TE MYOMECTOMY, abdominal (Ar	naes.) (Assist.)
35649	<b>Fee:</b> \$544.60 <b>Benefit:</b> 7.	75% = \$408.45	
	HYSTERECTOMY, ABDOMI adnexae (Anaes.) (Assist.)	INAL, SUBTOTAL or TOTAL, with	h or without removal of uterine
35653	Fee: \$685.50 Benefit: 7	75% = \$514.15	
	HYSTERECTOMY, VAGINAL 35673 applies	L, with or without uterine curettage,	not being a service to which item
	benefits are not payable for ser	nts apply in relation to sterilisation p vices not rendered in accordance wi e explanatory note before submitting	ith relevant Commonwealth and State
35657	(See para TN.8.46 of explanatory n <b>Fee:</b> \$685.50 <b>Benefit:</b> 7.	notes to this Category) 75% = \$514.15	
		n size to a 10 week gravid uterus), de	ebulking of, prior to vaginal removal
35658	(See para TN.8.47 of explanatory n <b>Fee:</b> \$422.70 <b>Benefit:</b> 7.	notes to this Category) 75% = \$317.05	
	exposure of 1 or both ureters, for	INAL, requiring extensive retroperite or the management of severe endome or without conservation of the ovarious of the ovario	etriosis, pelvic inflammatory disease
35661	Fee: \$885.25 Benefit: 7.	75% = \$663.95	
	uterine adnexae) for proven mal		ph nodes (with or without excision of or more of parametrium, paracolpos, olysis where performed (Anaes.)
35664	Fee: \$1,475.45 Benefit: 7	75% = \$1106.60	
	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnex for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagin contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)		netrium, paracolpos, upper vagina or
35667	Fee: \$1,254.00 Benefit: 7.	75% = \$940.50	
		al, with radical excision of pelvic lym	nph nodes, with or without removal
	of uterine adnexae (Anaes.) (As		
35670	· · · · · · · · · · · · · · · · · · ·	75% = \$774.45	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
35673		L (with or without uterine curettage) r more, 1 or both sides (Anaes.) (Ass	) with salpingectomy, oophorectomy sist.)

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICAL
	Fee: \$769.90	<b>Benefit:</b> 75% = \$577.45	
	ULTRASOUND	GUIDED NEEDLING and inject	ction of ectopic pregnancy
35674	(See para TN.4.11 <b>Fee:</b> \$211.20	of explanatory notes to this Category <b>Benefit:</b> 75% = \$158.40 859	
	ECTOPIC PREC	NANCY, removal of (Anaes.) (A	Assist.)
35677	Fee: \$544.60	<b>Benefit:</b> 75% = \$408.45	
	ECTOPIC PREC	NANCY, laparoscopic removal	of (Anaes.) (Assist.)
35678	Fee: \$656.60	<b>Benefit:</b> 75% = \$492.45	
	BICORNUATE	UTERUS, plastic reconstruction	for (Anaes.) (Assist.)
35680	Fee: \$591.35	<b>Benefit:</b> 75% = \$443.55 85%	6 = \$506.65
	UTERUS, SUSP	ENSION OR FIXATION OF, as	an independent procedure (Anaes.) (Assist.)
35684	<b>Fee:</b> \$478.70	<b>Benefit:</b> 75% = \$359.05	
	STERILISATIO		ECTION OF FALLOPIAN TUBES, via abdominal or or any other method
	benefits are not p and Territory lav	payable for services not rendered	n to sterilisation procedures on minors. Medicare in accordance with relevant Commonwealth and State before submitting a claim. (Anaes.) (Assist.)
35688	Fee: \$403.60	<b>Benefit:</b> 75% = \$302.70	
	with Caesarean s		LLOPIAN TUBES, when performed in conjunction
	benefits are not p	payable for services not rendered	n to sterilisation procedures on minors. Medicare in accordance with relevant Commonwealth and State refore submitting a claim. (Anaes.) (Assist.)
	_	of explanatory notes to this Category	y)
35691		<b>Benefit:</b> 75% = \$120.95 (salpingostomy, salpingolysis or or more procedures (Anaes.) (As	tubal implantation into uterus), UNILATERAL or sist.)
35694	<b>Fee:</b> \$647.90	<b>Benefit:</b> 75% = \$485.95	
	MICROSURGIO		omy, salpingolysis or tubal implantation into uterus), edures (Anaes.) (Assist.)
35697	<b>Fee:</b> \$961.35	<b>Benefit:</b> 75% = \$721.05	
			nastomosis of, using operating microscope (Anaes.)
35700	Fee: \$741 75	<b>Renefit:</b> 75% – \$556 35	
35700	<b>Fee:</b> \$741.75	<b>Benefit:</b> 75% = \$556.35	

T8. SUF	RGICAL OPERAT	TIONS	4. GYNAECOLOGICAL
		TION OF FALLOPIAN TUBES as a nonro a service to which another item in this Sub	
35703	Fee: \$68.60	<b>Benefit:</b> 75% = \$51.45 85% = \$58.35	
	RUBIN TEST F	FOR PATENCY OF FALLOPIAN TUBES	S (Anaes.)
35706	Fee: \$68.60	<b>Benefit:</b> 75% = \$51.45 85% = \$58.35	
	FALLOPIAN T	UBES, hydrotubation of, as a repetitive po	stoperative procedure (Anaes.)
35709	Fee: \$44.20	<b>Benefit:</b> 75% = \$33.15 85% = \$37.60	
	FALLOPOSCO (Assist.)	PY, unilateral or bilateral, including hyster	roscopy and tubal catheterization (Anaes.)
35710	Fee: \$470.70	<b>Benefit:</b> 75% = \$353.05	
	OOPHORECTO	Y, involving OOPHORECTOMY, SALPINDMY, removal of OVARIAN, PARAOVA h procedure, other than a service associated	RIAN, FIMBRIAL or BROAD LIGAMENT
35713	Fee: \$460.10	<b>Benefit:</b> 75% = \$345.10	
	OOPHORECTO	ore such procedures, unilateral or bilateral,	RIAN, FIMBRIAL or BROAD LIGAMENT
35717	Fee: \$554.00	<b>Benefit:</b> 75% = \$415.50	
	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.)		
35720	(See para TN.8.57 <b>Fee:</b> \$685.30	7 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$514.00	
		ONEAL LYMPH NODE BIOPSIES from a ging of gynaecological malignancy (Anaes.	above the level of the aortic bifurcation, for (Assist.)
35723	Fee: \$490.85	<b>Benefit:</b> 75% = \$368.15	
		OMENTECTOMY with multiple peritonea malignancy (Anaes.) (Assist.)	al biopsies for staging or restaging of
35726	Fee: \$490.85	<b>Benefit:</b> 75% = \$368.15	
	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for malignancy (Anaes.)		action with radical hysterectomy for invasive
35729	Fee: \$221.30	<b>Benefit:</b> 75% = \$166.00	
	Ovarian repositioning for one or both ovaries to preserve ovarian function, prior to gonadotoxic radiotherapy when the treatment volume and dose of radiation have a high probability of causing infertility (Anaes.)		
35730	Fee: \$221.30	<b>Benefit:</b> 75% = \$166.00	
	LAPAROSCOP (Anaes.) (Assist	PICALLY ASSISTED HYSTERECTOMY )	, including any associated laparoscopy
	1		

T8. SUF	RGICAL OPERATION	ONS	4. GYNAECOLOGICAL
	procedures: salpin	CALLY ASSISTED HYSTERECTOM negectomy, oophorectomy, excision of ce or both sides, including any associated	ovarian cyst or treatment of moderate
35753	Fee: \$881.50	<b>Benefit:</b> 75% = \$661.15	
	or other pathology when performed w	y, from the ureter, one or both sides, including the or more of the following process.	Y which requires dissection of endometriosis, cluding any associated laparoscopy, including edures: salpingectomy, oophorectomy, excision a service to which item 35641 applies (Anaes.)
35754	Fee: \$1,109.35	<b>Benefit:</b> 75% = \$832.05	
		CALLY ASSISTED HYSTERECTOM luding any associated laparoscopy (Ana	Y, when procedure is completed by open aes.) (Assist.)
35756	<b>Fee:</b> \$797.15	<b>Benefit:</b> 75% = \$597.90	
	under general anac		ORRHAGE following gynaecological surgery, al and vaginal approach where no other
35759	Fee: \$572.30	<b>Benefit:</b> 75% = \$429.25	
T8. SUF	RGICAL OPERATION	DNS	5. UROLOGICAL
	Group T8. Surgic	al Operations	
		Subgroup 5. U	rological
		GENERA	L
	PELVIC LYMPH (Assist.)	ADENECTOMY, open or laparoscopic	c, or both, unilateral or bilateral (Anaes.)
36502	Fee: \$694.85	<b>Benefit:</b> 75% = \$521.15	
	RENAL TRANSP	PLANT (not being a service to which it	em 36506 or 36509 applies) (Anaes.) (Assist.)
36503		Parasst. 750/ \$1000.05	
	<b>Fee:</b> \$1,413.40	<b>Benefit:</b> 75% = \$1060.05	
	RENAL TRANSP		and urologist operating together vascular
36506	RENAL TRANSP	PLANT, performed by vascular surgeon	n and urologist operating together vascular
36506	RENAL TRANSF anastomosis includ Fee: \$939.50 RENAL TRANSF	PLANT, performed by vascular surgeor ding aftercare (Anaes.) (Assist.)	n and urologist operating
36506 36509	RENAL TRANSF anastomosis includ Fee: \$939.50 RENAL TRANSF	PLANT, performed by vascular surgeor ding aftercare (Anaes.) (Assist.) <b>Benefit:</b> 75% = \$704.65  PLANT, performed by vascular surgeor	n and urologist operating
	RENAL TRANSF anastomosis include  Fee: \$939.50  RENAL TRANSF together ureterove  Fee: \$795.50	PLANT, performed by vascular surgeor ding aftercare (Anaes.) (Assist.)  Benefit: 75% = \$704.65  PLANT, performed by vascular surgeor esical anastomosis including aftercare (	n and urologist operating
	RENAL TRANSF anastomosis include  Fee: \$939.50  RENAL TRANSF together ureterove  Fee: \$795.50	PLANT, performed by vascular surgeor ding aftercare (Anaes.) (Assist.)  Benefit: 75% = \$704.65  PLANT, performed by vascular surgeor esical anastomosis including aftercare (  Benefit: 75% = \$596.65	n and urologist operating
36509	RENAL TRANSF anastomosis include Fee: \$939.50  RENAL TRANSF together ureterove Fee: \$795.50  NEPHRECTOMY Fee: \$939.50	PLANT, performed by vascular surgeording aftercare (Anaes.) (Assist.)  Benefit: 75% = \$704.65  PLANT, performed by vascular surgeoresical anastomosis including aftercare (Benefit: 75% = \$596.65  Y, complete (Anaes.) (Assist.)  Benefit: 75% = \$704.65	n and urologist operating

T8. SUF	RGICAL OPERATION	ONS	5. UROLOGICAL
	NEPHRECTOMY	, partial (Anaes.) (Assist.)	
36522	<b>Fee:</b> \$1,125.70	<b>Benefit:</b> 75% = \$844.30	
30322		y, partial, complicated by previous surgery on the sa	ame kidney (Anaes.) (Assist.)
26525			
36525	<b>Fee:</b> \$1,599.65	<b>Benefit:</b> 75% = \$1199.75	ith an without advanglantamy for a
	tumour less than 1	7, radical with en bloc dissection of lymph nodes, w Ocms in diameter, where performed if malignancy is opathological examination (Anaes.) (Assist.)	
36526	(See para TN.8.48 or <b>Fee:</b> \$1,311.75	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$983.85 85% = \$1227.05	
	tumour 10cms or same kidney, whe	r, radical with en bloc dissection of lymph nodes, we more in diameter, or complicated by previous open re performed if malignancy is clinically suspected by examination (Anaes.) (Assist.)	or laparoscopic surgery on the
36527	(See para TN.8.48 o <b>Fee:</b> \$1,618.90	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$1214.20 85% = \$1534.20	
		7, radical with en bloc dissection of lymph nodes, w 0 cms in diameter (Anaes.) (Assist.)	ith or without adrenalectomy, for a
36528	Fee: \$1,311.75	<b>Benefit:</b> 75% = \$983.85	
		<ul> <li>7, radical with en bloc dissection of lymph nodes, w more in diameter, or complicated by previous open es.) (Assist.)</li> </ul>	
36529	Fee: \$1,618.90	<b>Benefit:</b> 75% = \$1214.20	
		RECTOMY, complete, including associated bladde lures (Anaes.) (Assist.)	r repair and any associated
36531	Fee: \$1,176.40	<b>Benefit:</b> 75% = \$882.30	
		ERECTOMY, for tumour, with or without en bloc d repair and any associated endoscopic procedures (A	
36532	Fee: \$1,688.45	<b>Benefit:</b> 75% = \$1266.35	
	associated bladder	ERECTOMY, for tumour, with or without en bloc de repair and any associated endoscopic procedures, cery on the same kidney or ureter (Anaes.) (Assist.)	
36533	Fee: \$1,995.60	<b>Benefit:</b> 75% = \$1496.70	
		RINEPHRIC AREA, EXPLORATION OF, with or g a service to which another item in this Sub-group	
36537	Fee: \$702.45	<b>Benefit:</b> 75% = \$526.85	
	NEPHROLITHO stones (Anaes.) (A	TOMY OR PYELOLITHOTOMY, or both, through assist.)	n the same skin incision, for 1 or 2
36540	<b>Fee:</b> \$1,125.70	<b>Benefit:</b> 75% = \$844.30 85% = \$1041.00	
36543		TOMY OR PYELOLITHOTOMY, or both, extended or more of the following: nephrostomy, pyelostom	

T8. SUF	RGICAL OPERATION	DNS 5. UROLOGICAL
	freezing, calyorrha	aphy or pyeloplasty (Anaes.) (Assist.)
	<b>Fee:</b> \$1,311.75	<b>Benefit:</b> 75% = \$983.85 85% = \$1227.05
		EAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care ng pretreatment consultation, unilateral (Anaes.)
36546	Fee: \$702.45	<b>Benefit:</b> 75% = \$526.85 85% = \$617.75
	URETEROLITHO	OTOMY (Anaes.) (Assist.)
36549	Fee: \$846.45	<b>Benefit:</b> 75% = \$634.85
	NEPHROSTOMY	or pyelostomy, open, as an independent procedure (Anaes.) (Assist.)
36552	<b>Fee:</b> \$753.35	<b>Benefit:</b> 75% = \$565.05
	RENAL CYST O	R CYSTS, excision or unroofing of (Anaes.) (Assist.)
36558	Fee: \$660.20	<b>Benefit:</b> 75% = \$495.15 85% = \$575.50
	RENAL BIOPSY	(closed) (Anaes.)
36561	Fee: \$175.25	<b>Benefit:</b> 75% = \$131.45 85% = \$149.00
		(plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy sisted techniques (Anaes.) (Assist.)
36564	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65
		in a kidney that is congenitally abnormal in addition to the presence of PUJ a solitary kidney, by open exposure (Anaes.) (Assist.)
36567	Fee: \$1,032.55	<b>Benefit:</b> 75% = \$774.45
	PYELOPLASTY, (Assist.)	complicated by previous surgery on the same kidney, by open exposure (Anaes.)
36570	<b>Fee:</b> \$1,311.75	<b>Benefit:</b> 75% = \$983.85
	DIVIDED URETI	ER, repair of (Anaes.) (Assist.)
36573	<b>Fee:</b> \$939.50	<b>Benefit:</b> 75% = \$704.65
		re and exploration of, including repair or nephrectomy, for trauma, not being a service y other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.)
36576	<b>Fee:</b> \$1,176.40	<b>Benefit:</b> 75% = \$882.30
		Y, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a with a service to which item 37000 applies (Anaes.) (Assist.)
36579	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05
	URETER, transpla	antation of, into skin (Anaes.) (Assist.)
36585	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05
	URETER, reimpla	intation into bladder (Anaes.) (Assist.)
36588	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65
		*** ***

T8. SUF	RGICAL OPERATI	ONS	5. UROLOGICAL	
	URETER, reimpl	antation into bladder with psoas hitch or	Boari flap or both (Anaes.) (Assist.)	
36591	Fee: \$1,125.70	<b>Benefit:</b> 75% = \$844.30		
	URETER, transpl	antation of, into intestine (Anaes.) (Ass	ist.)	
36594	<b>Fee:</b> \$939.50	<b>Benefit:</b> 75% = \$704.65		
	URETER, transpl	antation of, into another ureter (Anaes.)	(Assist.)	
36597	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65		
	URETER, transpl	antation of, into isolated intestinal segm	nent, unilateral (Anaes.) (Assist.)	
36600	Fee: \$1,125.70	<b>Benefit:</b> 75% = \$844.30 85% = \$104	1.00	
	URETERS, transp	plantation of, into isolated intestinal seg	ment, bilateral (Anaes.) (Assist.)	
36603	<b>Fee:</b> \$1,311.75	<b>Benefit:</b> 75% = \$983.85		
	URETERIC STE techniques (Anae		phrostomy tube, using interventional imaging	
36604	Fee: \$271.95	<b>Benefit:</b> 75% = \$204.00 85% = \$231	.20	
	URETERIC STE	NT, insertion of, with removal of calcul-	us from:	
	(a) the pelvicalyceal system; or			
	(b) ureter; or			
	(c) the pelvical	yceal system and ureter;		
	through a nephros	stomy tube using interventional imaging	techniques (Anaes.)	
36605	<b>Fee:</b> \$701.75	<b>Benefit:</b> 75% = \$526.35		
		RINARY RESERVOIR, continent, formatation of ureters (1 or both) into reservo	nation of, including formation of nonreturn oir (Anaes.) (Assist.)	
36606	Fee: \$2,352.85	<b>Benefit:</b> 75% = \$1764.65		
	URETERIC STE	NT insertion of, with baloon dilatation of	of:	
	(a) the pelvicalyceal system; or			
	(b) ureter; or			
	(c) the pelvicalyceal system and ureter;			
	through a nephros	stomy tube using interventional imaging	techniques (Anaes.)	
36607	<b>Fee:</b> \$701.75	<b>Benefit:</b> 75% = \$526.35		
		nging techniques, not being a service ass	th either the ileal conduit or bladder, using sociated with a service to which items 36811 to	
36608	<b>Fee:</b> \$271.95	<b>Benefit:</b> 75% = \$204.00		
36609		RINARY CONDUIT OR URETEROST	OMY, revision of (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERAT	ONS 5. UROLOGICAL		
	<b>Fee:</b> \$753.35	<b>Benefit:</b> 75% = \$565.05		
	URETER, explo	ation of, with or without drainage of, as an independent procedure (Anaes.) (Assist.)		
36612	Fee: \$660.20	<b>Benefit:</b> 75% = \$495.15		
	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.)			
36615	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05		
	REDUCTION U	RETEROPLASTY (Anaes.) (Assist.)		
36618	Fee: \$660.20	<b>Benefit:</b> 75% = \$495.15		
	CLOSURE OF C	UTANEOUS URETEROSTOMY (Anaes.) (Assist.)		
36621	<b>Fee:</b> \$471.95	<b>Benefit:</b> 75% = \$354.00		
	NEPHROSTOM	Y, percutaneous, using interventional imaging techniques (Anaes.) (Assist.)		
36624	<b>Fee:</b> \$567.05	<b>Benefit:</b> 75% = \$425.30 85% = \$482.35		
30021	NEPHROSCOP	7, percutaneous, with or without any 1 or more of; stone extraction, biopsy or ing a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.)		
36627	Fee: \$702.45	<b>Benefit:</b> 75% = \$526.85		
	substantial portion	7, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a n of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE JE TO BLEEDING (Anaes.) (Assist.)		
36630	Fee: \$346.95	<b>Benefit:</b> 75% = \$260.25		
	ureter and include	7, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ng antegrade insertion of ureteric stent, not being a service associated with a service to 7, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)		
36633	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05 85% = \$668.65		
	ureter and includ	7, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ng antegrade insertion of ureteric stent, being a service associated with a service to 7, 36639, 36642, 36645 or 36648 applies (Anaes.) (Assist.)		
36636	<b>Fee:</b> \$406.30	<b>Benefit:</b> 75% = \$304.75		
		7, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or shock waves or lasers (not being a service to which item 36645 or 36648 applies)		
36639	Fee: \$846.45	<b>Benefit:</b> 75% = \$634.85		
	substantial portion	Y, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a n of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE JE TO BLEEDING (Anaes.) (Assist.)		
36642	<b>Fee:</b> \$423.10	<b>Benefit:</b> 75% = \$317.35		
		7, percutaneous, with removal or destruction of a stone greater than 3 cm in any 3 or more stones (Anaes.) (Assist.)		
	<b>Fee:</b> \$1,083.35	<b>Benefit:</b> 75% = \$812.55		

T8. SUF	RGICAL OPERATIONS	5. UROLOGICAL
	NEPHROSCOPY, being a service to which item 36645 applies, WHERE the procedure has been performed, IT IS NECESSARY TO DISCONTIN (Anaes.) (Assist.)	
36648	<b>Fee:</b> \$964.80 <b>Benefit:</b> 75% = \$723.60	
	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including i	imaging (Anaes.) (Assist.)
36649	<b>Fee:</b> \$271.95 <b>Benefit:</b> 75% = \$204.00 85% = \$231.20	
	NEPHROSTOMY TUBE, removal of, if the ureter has been stented with that stent is left in place, using interventional imaging techniques (Anaes.	
36650	<b>Fee:</b> \$152.10 <b>Benefit:</b> 75% = \$114.10	
	PYELOSCOPY, retrograde, of one collecting system, with or without any ureteric meatotomy, ureteric dilatation, not being a service associated wit 36803, 36812 or 36824 applies (Anaes.) (Assist.)	
36652	<b>Fee:</b> \$660.20 <b>Benefit:</b> 75% = \$495.15	
	PYELOSCOPY, retrograde, of one collecting system, being a service to value of or more of extraction of stone from the renal pelvis or calyces, or biops pelvis or calyces, not being a service associated with a service to which it procedure performed in the same collecting system (Anaes.) (Assist.)	y or diathermy of the renal
36654	<b>Fee:</b> \$846.45 <b>Benefit:</b> 75% = \$634.85	
	PYELOSCOPY, retrograde, of one collecting system, being a service to vextraction of 2 or more stones in the renal pelvis or calyces or destruction electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyce fragments, not being a service associated with a service to which item 360 performed in the same collecting system (Anaes.) (Assist.)	of stone with ultrasound, es, with or without extraction of
36656	<b>Fee:</b> \$1,083.35 <b>Benefit:</b> 75% = \$812.55	
	OPERATIONS ON BLADDER	
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an accatheterisation, with biopsy of bladder, not being a service associated wit 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854 or 37233 applies.	h a service to which item
	(Anaes.)	
36504	(See para TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$299.55 <b>Benefit:</b> 75% = \$224.70 85% = \$254.65	
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an accatheterisation, with urethroscopy with or without urethral dilatation, not any other urological endoscopic procedure on the lower urinary tract exce 37327 applies.	being a service associated with
	(Anaes.)	
36505	(See para TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$235.40 <b>Benefit:</b> 75% = \$176.55 85% = \$200.10	

T8. SUR	RGICAL OPERATIONS	5. UROLOGICAL	
	RIGID CYSTOSCOPY using blue light with hexaminolevul catheterisation, with resection, diathermy or visual laser dest the bladder, not being a service to which item 36840 or 3684	ruction of bladder tumour or other lesion of	
	(Anaes.)		
36507	(See para TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$394.40 <b>Benefit:</b> 75% = \$295.80 85% = \$335.25		
	RIGID CYSTOSCOPY using blue light with hexaminolevul catheterisation, with diathermy, resection or visual laser desi quadrants of the bladder or solitary tumour greater than 2cm item 36845 applies.	truction of multiple tumours in more than 2	
	(Anaes.)		
36508	(See para TN.8.2 of explanatory notes to this Category) <b>Fee:</b> \$768.50 <b>Benefit:</b> 75% = \$576.40 85% = \$683.80		
	Both:		
	(a) percutaneous placement of sacral nerve lead or leads using of sacral nerve lead or leads; and	ng fluoroscopic guidance, or open placement	
	(b) intra-operative test stimulation, to manage:		
	(i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or		
	(ii) non-obstructive urinary retention that has been refr non-surgical treatment	actory to at least 12 months conservative	
	(Anaes.)		
36663	<b>Fee:</b> \$671.55 <b>Benefit:</b> 75% = \$503.70 85% = \$586.85		
	Both:		
	(a) percutaneous repositioning of sacral nerve lead or leads u repositioning of sacral nerve lead or leads; and	ising fluoroscopic guidance, or open	
	(b) intra-operative test stimulation, to correct displacement of the management of:	or unsatisfactory positioning, if inserted for	
	(i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or		
	(ii) non-obstructive urinary retention that has been refr non-surgical treatment	actory to at least 12 months conservative	
	—other than a service to which item 36663 applies (An	naes.)	
36664	<b>Fee:</b> \$603.05 <b>Benefit:</b> 75% = \$452.30 85% = \$518.35		
	Sacral nerve electrode or electrodes, management and adjust practitioner, to manage detrusor overactivity or non obstruct		
36665	<b>Fee:</b> \$127.40 <b>Benefit:</b> 75% = \$95.55 85% = \$108.30		

T8. SUF	RGICAL OPERATIONS	5. UROLOGICAL	
	Pulse generator, subcutaneous placement of, and placement and connection of esacral nerve electrode or electrodes, for the management of:	extension wire or wires to	
	(a) detrusor over-activity that has been refractory to at least 12 months conservatreatment; or	ative non-surgical	
	(b) non-obstructive urinary retention that has been refractory to at least 12 monnon-surgical treatment (Anaes.)	ths conservative	
36666	<b>Fee:</b> \$339.35 <b>Benefit:</b> 75% = \$254.55 85% = \$288.45		
	Sacral nerve lead or leads, removal of, if the lead was inserted to manage:		
	(a) detrusor over-activity that has been refractory to at least 12 months conservatreatment; or	ative non-surgical	
	(b) non-obstructive urinary retention that has been refractory to at least 12 months non-surgical treatment	ths conservative	
	(Anaes.)		
36667	<b>Fee:</b> \$158.80 <b>Benefit:</b> 75% = \$119.10 85% = \$135.00		
	Pulse generator, removal of, if the pulse generator was inserted to manage:		
	(a) detrusor over-activity that has been refractory to at least 12 months conservatreatment; or	ative non-surgical	
	(b) non-obstructive urinary retention that has been refractory to at least 12 monnon-surgical treatment	ths conservative	
	(Anaes.)		
36668	<b>Fee:</b> \$158.80 <b>Benefit:</b> 75% = \$119.10 85% = \$135.00		
	Percutaneous tibial nerve stimulation, initial treatment protocol, for the treatment by a specialist urologist, gynaecologist or urogynaecologist, if:	nt of overactive bladder,	
	(a) the patient has been diagnosed with idiopathic overactive bladder; and		
	(b) the patient has been refractory to, is contraindicated or otherwise not suitable for conservative treatments (including anti-cholinergic agents); and		
	(c) the patient is contraindicated or otherwise not a suitable candidate for botuli therapy; and	num toxin type A	
	(d) the patient is contraindicated or otherwise not a suitable candidate for sacral	nerve stimulation; and	
	(e) the patient is willing and able to comply with the treatment protocol; and		
	(f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month period; and		
	(g) each session lasts for a minimum of 45 minutes, of which neurostimulation		
36671	For each patient—applicable only once, unless the patient achieves at least a 50		
200/1	approache only once, amoss the patient active at least a so		

T8. SUR	GICAL OPERATI	ONS		5. UROLOGICAL
	overactive bladde	er symptoms from baseline a	at any time during the 3 month treatme	ent period.
	Not applicable fo	r a service associated with a	service to which item 36672 or 3667	3 applies
	Fee: \$203.20	<b>Benefit:</b> 75% = \$152.40	85% = \$172.75	
		g any associated consultatio	ng treatment protocol, for the treatment at the time the percutaneous tibial n	
	achieved at least		tibial nerve stimulation initial treatme we bladder symptoms from baseline a ocol; and	
			no more than 5 sessions, delivered or with the aim of sustaining therapeutic	
	(c) each session l	asts for a minimum of 45 m	inutes, of which neurostimulation last	es for 30 minutes.
	Not applicable fo	r a service associated with a	service to which item 36671 or 3667	73 applies
36672	Fee: \$203.20	<b>Benefit:</b> 75% = \$152.40		
		g any associated consultatio	nance treatment protocol, for the trea n at the time the percutaneous tibial n	
	tapering treatmen	t protocol, and has achieved	tibial nerve stimulation initial treatment at least a 50% reduction in overactive transfer of the initial treatment protocol.	e bladder symptoms
			rises no more than 12 sessions, delive djusted with the aim of sustaining the	
	(c) each session l	asts for a minimum of 45 m	inutes, of which neurostimulation last	s for 30 minutes.
	Not applicable fo	r service associated with a s	ervice to which item 36671 or 36672	applies
36673	Fee: \$203.20	<b>Benefit:</b> 75% = \$152.40	85% = \$172.75	
	BLADDER, cath	eterisation of, where no other	er procedure is performed (Anaes.)	
36800	Fee: \$28.05	<b>Benefit:</b> 75% = \$21.05	85% = \$23.85	
	or ureteric dilatat	ion, not being a service asso	thout any one or more of; cystoscopy ociated with a service to which item 30 or 36857 applies (Anaes.) (Assist.)	
36803	(See para TN.8.51 <b>Fee:</b> \$473.80	of explanatory notes to this Cat <b>Benefit:</b> 75% = \$355.35		

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICAL
	or ureteric dilatat the ureter, not bei service associated	PY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy ion, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of ng a service associated with a service to which item 36803 or 36812 applies, or a l with a service to which item 36809, 36824, 36848 or 36857 applies to a procedure same ureter (Anaes.) (Assist.)
36806	Fee: \$660.20	<b>Benefit:</b> 75% = \$495.15
	or ureteric dilatate lithotripsy, or lase to which item 368	Y, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy ion, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic er, with or without extraction of fragments, not being a service associated with a service 303 or 36812 applies, or a service associated with a service to which item 36806, 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.)
36809	Fee: \$846.45	<b>Benefit:</b> 75% = \$634.85
	CYSTOSCOPY	with insertion of urethral prosthesis (Anaes.)
36811	Fee: \$328.55	<b>Benefit:</b> 75% = \$246.45 85% = \$279.30
		with urethroscopy with or without urethral dilatation, not being a service associated ological endoscopic procedure on the lower urinary tract except a service to which item naes.)
36812	<b>Fee:</b> \$169.35	<b>Benefit:</b> 75% = \$127.05 85% = \$143.95
		with or without urethroscopy, for the treatment of penile warts or uretheral warts, not sociated with a service to which item 30189 applies (Anaes.)
36815	(See para TN.8.9 of <b>Fee:</b> \$241.70	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$181.30 85% = \$205.45
		with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, eral, not being a service associated with a service to which item 36824 or 36830 applies
36818	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90
		with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of lvis, unilateral, not being a service associated with a service to which item 36824 or naes.) (Assist.)
36821	Fee: \$328.35	<b>Benefit:</b> 75% = \$246.30 85% = \$279.10
		with ureteric catheterisation, unilateral or bilateral, not being a service associated with a item 36818 or 36821 applies (Anaes.)
36824	Fee: \$216.55	<b>Benefit:</b> 75% = \$162.45 85% = \$184.10
	removal or replac	with endoscopic incision of pelviureteric junction or ureteric stricture, including ement of ureteric stent, not being a service associated with a service to which item 824, 36830 or 36833 applies (Anaes.) (Assist.)
36825	Fee: \$590.60	<b>Benefit:</b> 75% = \$442.95
	CYSTOSCOPY,	with controlled hydrodilatation of the bladder (Anaes.)
36827	Fee: \$233.55	<b>Benefit:</b> 75% = \$175.20 85% = \$198.55
36830	CYSTOSCOPY,	with ureteric meatotomy (Anaes.)

T8. SUF	RGICAL OPERAT	TIONS 5. UROLOGICAL
	Fee: \$206.50	<b>Benefit:</b> 75% = \$154.90
	CYSTOSCOPY	, with removal of ureteric stent or other foreign body (Anaes.) (Assist.)
36833	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90
		, with biopsy of bladder, not being a service associated with a service to which item 6840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies (Anaes.)
36836	(See para TN.8.2 ( <b>Fee:</b> \$233.55	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$175.20 85% = \$198.55
		, with resection, diathermy or visual laser destruction of bladder tumour or other lesion ot being a service to which item 36845 applies (Anaes.)
36840	Fee: \$328.35	<b>Benefit:</b> 75% = \$246.30 85% = \$279.10
	or bladder and n	, with lavage of blood clots from bladder including any associated diathermy of prostate ot being a service associated with a service to which item 36812, 36827 to 36863, 37203 (Anaes.) (Assist.)
36842	Fee: \$330.40	<b>Benefit:</b> 75% = \$247.80
		, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 bladder or solitary tumour greater than 2cm in diameter (Anaes.)
36845	Fee: \$702.45	<b>Benefit:</b> 75% = \$526.85 85% = \$617.75
	CYSTOSCOPY	, with resection of ureterocele (Anaes.)
36848	Fee: \$233.55	<b>Benefit:</b> 75% = \$175.20
		h injection into bladder wall, other than a service associated with a service to which item applies (H) (Anaes.)
36851	Fee: \$233.55	<b>Benefit:</b> 75% = \$175.20
	CYSTOSCOPY (Anaes.)	, with endoscopic incision or resection of external sphincter, bladder neck or both
36854	Fee: \$473.80	<b>Benefit:</b> 75% = \$355.35
	ENDOSCOPIC	MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.)
36857	Fee: \$372.30	<b>Benefit:</b> 75% = \$279.25
	ENDOSCOPIC	EXAMINATION of intestinal conduit or reservoir (Anaes.)
36860	Fee: \$169.35	<b>Benefit:</b> 75% = \$127.05 85% = \$143.95
	LITHOLAPAX	Y, with or without cystoscopy (Anaes.) (Assist.)
36863	<b>Fee:</b> \$473.80	<b>Benefit:</b> 75% = \$355.35
		tial excision of (Anaes.) (Assist.)
37000	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05
51000		air of rupture (Anaes.) (Assist.)
27004		
37004 37008	Fee: \$660.20	<b>Benefit:</b> 75% = \$495.15 Y OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and
2/008	CISTOSTOMI	OK C151010M1, suprapuole, not being a service to which item 57011 applies and

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL
	not being a servi	ce associated with other open bladder procedure (Anaes.)
	Fee: \$423.10	<b>Benefit:</b> 75% = \$317.35 85% = \$359.65
	SUPRAPUBIC S 37200 to 37221 a	STAB CYSTOTOMY, not being a service associated with a service to which items apply (Anaes.)
37011	Fee: \$94.85	<b>Benefit:</b> 75% = \$71.15 85% = \$80.65
	BLADDER, tota	l excision of (Anaes.) (Assist.)
37014	Fee: \$1,083.35	<b>Benefit:</b> 75% = \$812.55
	BLADDER DIV	ERTICULUM, excision or obliteration of (Anaes.) (Assist.)
37020	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05
		ULA, cutaneous, operation for (Anaes.)
37023	<b>Fee:</b> \$423.10	<b>Benefit:</b> 75% = \$317.35
37023		/ESICOSTOMY, establishment of (Anaes.) (Assist.)
37026	<b>Fee:</b> \$423.10	<b>Benefit:</b> 75% = \$317.35
37020		AL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.)
27020		
37029	<b>Fee:</b> \$939.50	Benefit: 75% = \$704.65  FINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.)
37038	Fee: \$702.80	<b>Benefit:</b> 75% = \$527.10
		continence, sling procedure for, using a non-adjustable synthetic male sling system, mesh, other than a service associated with a service to which item 30405, 35599 or mass.) (Assist.)
37040	Fee: \$925.90	<b>Benefit:</b> 75% = \$694.45
	BLADDER ASP	PIRATION by needle
37041	<b>Fee:</b> \$47.35	<b>Benefit:</b> 75% = \$35.55 85% = \$40.25
	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.)	
37042	Fee: \$925.90	<b>Benefit:</b> 75% = \$694.45
		ESS INCONTINENCE, Stamey or similar type needle colposuspension, with or of being a service associated with a service to which item 30405 or 35599 applies
37043	<b>Fee:</b> \$685.30	<b>Benefit:</b> 75% = \$514.00
		ESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with or of being a service associated with a service to which item 30405 or 35599 applies
37044	Fee: \$702.80	<b>Benefit:</b> 75% = \$527.10
37045	CONTINENT C. (Assist.)	ATHETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.)

T8. SUF	GICAL OPERATION	S	5. UROLOGICAL
	Fee: \$1,451.60	<b>Benefit:</b> 75% = \$1088.70	
	BLADDER ENLAR	GEMENT using intestine (Anaes.) (Assist.)	
37047	<b>Fee:</b> \$1,692.70	<b>Benefit:</b> 75% = \$1269.55	
	BLADDER EXSTRO	OPHY CLOSURE, not involving sphincter reconstruct	tion (Anaes.) (Assist.)
37050	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05	
		ECTION AND RE-ANASTOMOSIS TO TRIGONE (	(Anaes.) (Assist.)
37053	<b>Fee:</b> \$870.40	<b>Benefit:</b> 75% = \$652.80	
	2 661 \$676116	OPERATIONS ON PROSTATE	
	PROSTATECTOMY	, open (Anaes.) (Assist.)	
37200	Fee: \$1,032.55	<b>Benefit:</b> 75% = \$774.45	
	without urethroscopy medically fit for tran	ethral radio-frequency needle ablation of, with or with a patients with moderate to severe lower urinary transported resection of the prostate (that is, prostatecton services to which item 36854, 37203, 37206, 37207, aes.)	ct symptoms who are not ny using diathermy or cold
37201		xplanatory notes to this Category) <b>Benefit:</b> 75% = \$631.60	
	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.)		
37202		splanatory notes to this Category) <b>Benefit:</b> 75% = \$317.05	
	or without urethrosco	Y (endoscopic, using diathermy or cold punch), with or ppy, and including services to which item 36854, 3720 or 37324 applies (Anaes.)	
37203	Fee: \$1,058.80	<b>Benefit:</b> 75% = \$794.10	
	or without urethrosco continuation of, with	Y (endoscopic, using diathermy or cold punch), with or opy, and including services to which item 36854, 3730 in 10 days of the procedure described by item 37201, and for medical reasons (Anaes.)	3, 37321 or 37324 applies,
37206	Fee: \$567.05	<b>Benefit:</b> 75% = \$425.30	
	with or without ureth	opic non-contact (side firing) visual laser ablation, wit roscopy, and including services to which items 36854 or 37324 applies (Anaes.)	
37207	Fee: \$880.30	<b>Benefit:</b> 75% = \$660.25	
37208	with or without ureth	opic non-contact (side firing) visual laser ablation, wit roscopy, and including services to which item 36854, of, within 10 days of the procedure described by item	37303, 37321 or 37324

T8. SUF	RGICAL OPERATION	ONS	5. UROLOGICAL
	37245 which had t	o be discontinued for medical reasons (Anaes.)	
	Fee: \$422.70	<b>Benefit:</b> 75% = \$317.05	
		or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or vice associated with a service to which item number 37210 or	
37209	Fee: \$1,311.75	<b>Benefit:</b> 75% = \$983.85	
	bladder and bladde	MY, radical, involving total excision of the prostate, sparing or neck reconstruction, not being a service associated with a s 7375 applies (Anaes.) (Assist.)	
37210	Fee: \$1,618.90	<b>Benefit:</b> 75% = \$1214.20	
	bladder and bladde	MY, radical, involving total excision of the prostate, sparing or neck reconstruction, with pelvic lymphadenectomy, not beightich item 35551, 36502 or 37375 applies (Anaes.) (Assist.)	
37211	Fee: \$1,966.15	<b>Benefit:</b> 75% = \$1474.65	
	PROSTATE, oper	perineal biopsy or open drainage of abscess (Anaes.) (Assist	t.)
37212	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80	
	PROSTATE, biop	sy of, endoscopic, with or without cystoscopy (Anaes.) (Assi	st.)
37215	<b>Fee:</b> \$423.10	<b>Benefit:</b> 75% = \$317.35 85% = \$359.65	
	Prostate, implanta (Anaes.)	tion of radio-opaque fiducial markers into the prostate gland	or prostate surgical bed
37217	(See para TN.8.54 o <b>Fee:</b> \$140.50	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$105.40 85% = \$119.45	
	PROSTATE, need	lle biopsy of, or injection into, excluding for insertion of radio	opaque markers (Anaes.)
37218	Fee: \$140.50	<b>Benefit:</b> 75% = \$105.40 85% = \$119.45	
		lle biopsy of, using prostatic ultrasound techniques and obtain a service associated with a service to which item 55600 or 55	
37219	Fee: \$285.35	<b>Benefit:</b> 75% = \$214.05 85% = \$242.55	
	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.)		
37220	(See para TN.8.55 o <b>Fee:</b> \$1,060.90	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$795.70	
	PROSTATIC ABS	SCESS, endoscopic drainage of (Anaes.) (Assist.)	
37221	<b>Fee:</b> \$473.80	<b>Benefit:</b> 75% = \$355.35	
37223	PROSTATIC CO	L, insertion of, under ultrasound control (Anaes.)	

T8. SUF	RGICAL OPERAT	TONS	5. UROLOGICAL
	Fee: \$209.55	<b>Benefit:</b> 75% = \$157.20	
		athermy or visual laser destruction of lesion of, item 37201, 37202, 37203, 37206, 37207, 372	
37224	Fee: \$328.35	<b>Benefit:</b> 75% = \$246.30 85% = \$279.10	
	guidance includi	insperineal insertion of catheters into, for high cing any associated cystoscopy. The procedure na radiation oncologist, and be associated with a	nust be performed at an approved site in
37227	(See para TN.8.56 <b>Fee:</b> \$574.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$431.20 85% = \$490.20	
	with or without i	gh-energy transurethral microwave thermothera urethroscopy and including services to which it 37324 applies (Anaes.)	
37230	Fee: \$1,058.80	<b>Benefit:</b> 75% = \$794.10 85% = \$974.10	
	with or without u	gh-energy transurethral microwave thermothera urethroscopy and including services to which it ation of, within 10 days of the procedure describ discontinued for medical reasons (Anaes.)	em 36854, 37303, 37321 or 37324
37233	Fee: \$567.05	<b>Benefit:</b> 75% = \$425.30 85% = \$482.35	
	Prostate, endoscopic enucleation of, using high powered Holmium: YAG laser and an end-firing, n contact fibre, with or without tissue morcellation, cystoscopy or urethroscopy, for the treatment of benign prostatic hyperplasia, and other than a service associated with a service to which item 3685 37201, 37202, 37203, 37206, 37207, 37208, 37303, 37321, or 37324 applies. (Anaes.)		r urethroscopy, for the treatment of d with a service to which item 36854,
37245	Fee: \$1,282.35	<b>Benefit:</b> 75% = \$961.80	
		OPERATIONS ON URETHRA, PENIS	OR SCROTUM
	URETHRAL SO	OUNDS, passage of, as an independent procedu	are (Anaes.)
37300	Fee: \$47.35	<b>Benefit:</b> 75% = \$35.55 85% = \$40.25	
	URETHRAL ST	TRICTURE, dilatation of (Anaes.)	
37303	Fee: \$75.25	<b>Benefit:</b> 75% = \$56.45 85% = \$64.00	
	+	air of rupture of distal section (Anaes.) (Assist.)	)
37306	Fee: \$660.20	<b>Benefit:</b> 75% = \$495.15	
37300		air of rupture of prostatic or membranous segm	ent (Anaes.) (Assist.)
37309	Fee: \$939.50 Benefit: 75% = \$704.65		
37307	URETHROSCOPY, as an independent procedure (Anaes.)		
37315		•	
31313	Fee: \$140.50 Benefit: 75% = \$105.40 85% = \$119.45  URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.)		visual laser destruction of stone or
37318	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90	

RGICAL OPERAT	TIONS 5. UROLOGICAL			
Fee: \$94.85	<b>Benefit:</b> 75% = \$71.15 85% = \$80.65			
URETHROTO	MY OR URETHROSTOMY, internal or external (Anaes.)			
Fee: \$233.55	<b>Benefit:</b> 75% = \$175.20			
URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.)				
Fee: \$328.35	<b>Benefit:</b> 75% = \$246.30			
URETHRECTO	OMY, partial or complete, for removal of tumour (Anaes.) (Assist.)			
Fee: \$660.20	<b>Benefit:</b> 75% = \$495.15			
	GINAL FISTULA, closure of (Anaes.) (Assist.)			
Fac: \$567.05	<b>Benefit:</b> 75% = \$425.30			
	CTAL FISTULA, closure of (Anaes.) (Assist.)			
	<b>Benefit:</b> 75% = \$565.05 ic male sling system, division or removal of, for urethral obstruction or erosion,			
following previous	ous surgery for urinary incontinence, other than a service associated with a service to 40 or 37341 applies (Anaes.) (Assist.)			
Fee: \$925.90	<b>Benefit:</b> 75% = \$694.45			
Periurethral or transurethral injection of materials for the treatment of urinary incontinence, cystoscopy and urethroscopy, other than a service associated with a service to which item 1 18379 applies (Anaes.)				
Fee: \$243.70	<b>Benefit:</b> 75% = \$182.80 85% = \$207.15			
surgery for urina	LING, division or removal of, for urethral obstruction or erosion, following previous ary incontinence, vaginal approach, not being a service associated with a service to ber 37341 applies (Anaes.) (Assist.)			
Fee: \$431.80	<b>Benefit:</b> 75% = \$323.85			
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: \$925.90	<b>Benefit:</b> 75% = \$694.45			
URETHROPLA	ASTY single stage operation (Anaes.) (Assist.)			
Fee: \$846.45	<b>Benefit:</b> 75% = \$634.85			
below the symp	ASTY, single stage operation, transpubic approach via separate incisions above and hysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or ng of the urethra around the crura (Anaes.) (Assist.)			
Fee: \$1,413.40	<b>Benefit:</b> 75% = \$1060.05			
URETHROPLA	STY 2 stage operation first stage (Anaes.) (Assist.)			
Fee: \$702.45	<b>Benefit:</b> 75% = \$526.85			
URETHROPLA	ASTY 2 stage operation second stage (Anaes.) (Assist.)			
Fee: \$702.45	<b>Benefit:</b> 75% = \$526.85			
	URETHROTON Fee: \$233.55  URETHROTON Fee: \$328.35  URETHRECTO Fee: \$660.20  URETHROVAC Fee: \$567.05  URETHROREC Fee: \$753.35  Urethral synthet following previous which item 3734 Fee: \$925.90  Periurethral or trecystoscopy and a 18379 applies (AFE) Fee: \$243.70  URETHRAL SI surgery for urina which item num Fee: \$431.80  URETHRAL SI surgery for urina which item num Fee: \$431.80  URETHROPLA Fee: \$925.90  URETHROPLA Fee: \$925.90  URETHROPLA Fee: \$943.40  URETHROPLA Fee: \$1,413.40  URETHROPLA Fee: \$702.45  URETHROPLA			

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICAL
	URETHROPLAS	TY, not being a service to which another item in this Group applies (Anaes.) (Assist.)
37351	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80
	HYPOSPADIAS.	, meatotomy and hemicircumcision (Anaes.) (Assist.)
37354	Fee: \$328.35	<b>Benefit:</b> 75% = \$246.30
	URETHRA, excis	sion of prolapse of (Anaes.)
37369	Fee: \$189.60	<b>Benefit:</b> 75% = \$142.20
	URETHRAL DIV	/ERTICULUM, excision of (Anaes.) (Assist.)
37372	Fee: \$473.80	<b>Benefit:</b> 75% = \$355.35
	URETHRAL SPI (Anaes.) (Assist.)	HINCTER, reconstruction by bladder tubularisation technique or similar procedure
37375	Fee: \$1,176.40	<b>Benefit:</b> 75% = \$882.30
	ARTIFICIAL UR	RINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.)
37381	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05
	ARTIFICIAL UR	RINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.)
37384	Fee: \$1,176.40	<b>Benefit:</b> 75% = \$882.30
	ARTIFICIAL UR (Assist.)	RINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.)
37387	Fee: \$328.35	<b>Benefit:</b> 75% = \$246.30
	ARTIFICIAL UR (Assist.)	RINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.)
37390	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65
	PRIAPISM, deco without lavage (A	mpression by glanular stab cavernosospongiosum shunt or penile aspiration with or anaes.)
37393	Fee: \$233.55	<b>Benefit:</b> 75% = \$175.20 85% = \$198.55
	PRIAPISM, shun	t operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)
37396	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05
	PENIS, partial an	nputation of (Anaes.) (Assist.)
37402	Fee: \$473.80	<b>Benefit:</b> 75% = \$355.35
	PENIS, complete	or radical amputation of (Anaes.) (Assist.)
37405	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65
	PENIS, repair of	laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)
37408	Fee: \$473.80	<b>Benefit:</b> 75% = \$355.35
	PENIS, repair of	avulsion (Anaes.) (Assist.)
37411	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65 85% = \$854.80
37415	PENIS, injection	of, for the investigation and treatment of impotence - 2 services only in a period of 36

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICAL	
	consecutive mont	ths	
	Fee: \$47.35	<b>Benefit:</b> 75% = \$35.55 85% = \$40.25	
	PENIS, correction grafting (Anaes.)	n of chordee, with or without excision of fibrous plaque or plaques and with or without (Assist.)	
37417	<b>Fee:</b> \$567.05	<b>Benefit:</b> 75% = \$425.30	
		n of chordee, with or without excision of fibrous plaque or plaques and with or without g mobilization of the urethra (Anaes.) (Assist.)	
37418	Fee: \$753.35	<b>Benefit:</b> 75% = \$565.05 85% = \$668.65	
		o inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's or more deep cavernosal veins with or without pharmacological erection test (Anaes.)	
37420	Fee: \$372.30	<b>Benefit:</b> 75% = \$279.25	
	PENIS, lengtheni	ing by translocation of corpora (Anaes.) (Assist.)	
37423	<b>Fee:</b> \$939.50	<b>Benefit:</b> 75% = \$704.65	
	PENIS, artificial	erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.)	
37426	<b>Fee:</b> \$990.15	<b>Benefit:</b> 75% = \$742.65	
	PENIS, artificial	erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.)	
37429	Fee: \$328.35	\$328.35 <b>Benefit:</b> 75% = \$246.30	
	PENIS, artificial replacement (Ana	erection device, complete or partial revision or removal of components, with or without aes.) (Assist.)	
37432	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65	
	PENIS, frenulopl	asty as an independent procedure (Anaes.)	
37435	Fee: \$94.85	<b>Benefit:</b> 75% = \$71.15 85% = \$80.65	
	SCROTUM, part	ial excision of (Anaes.) (Assist.)	
37438	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90	
	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.)		
37444	Fee: \$1,015.65	<b>Benefit:</b> 75% = \$761.75 85% = \$930.95	
		OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES	
	SPERMATOCEI	LE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.)	
37601	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90	
		OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, ing a service associated with sperm harvesting for IVF (Anaes.)	
37604	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90	
37605	Transcutaneous s	perm retrieval, unilateral, from either the testis or the epididymis, for the purposes nic sperm injection, for male factor infertility, excluding a service to which item 13218	

10. 501	RGICAL OPERAT	IONS	5. UROLOGICAL		
	applies. (Anaes.)				
	(See para TN.8.58, <b>Fee:</b> \$379.45	, TN.1.5 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$284.60 85% = \$322.55			
	biopsy, for the pu	perm retrieval, unilateral, including the exploration urposes of intracytoplasmic sperm injection, for n ng a service to which item 13218 or 37604 applies	nale factor infertility, performed in a		
37606	(See para TN.1.5, ' <b>Fee:</b> \$563.40	TN.8.59 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$422.55 85% = \$478.90			
		NEAL LYMPH NODE DISSECTION, unilateral item 36528 applies (Anaes.) (Assist.)	l, not being a service associated with a		
37607	Fee: \$939.50	<b>Benefit:</b> 75% = \$704.65			
	service to which	NEAL LYMPH NODE DISSECTION, unilateral item 36528 applies, following previous similar retradiation or chemotherapy (Anaes.) (Assist.)			
37610	Fee: \$1,413.40	<b>Benefit:</b> 75% = \$1060.05			
	EPIDIDYMECT	OMY (Anaes.)			
37613	Fee: \$281.05	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90			
		OMY or VASOEPIDIDYMOSTOMY, unilateral associated with sperm harvesting for IVF (Anaes.)			
37616	Fee: \$702.45	<b>Benefit:</b> 75% = \$526.85			
		OMY or VASOEPIDIDYMOSTOMY, unilateral	, not being a service associated with		
	sperm harvesting for IVF (Anaes.) (Assist.)				
37619	Fee: \$281.05 Extended Medic	<b>Benefit:</b> 75% = \$210.80 85% = \$238.90 <b>care Safety Net Cap:</b> \$224.85			
	VASOTOMY O	R VASECTOMY, unilateral or bilateral			
	benefits are not p	gal requirements apply in relation to sterilisation payable for services not rendered in accordance v w. Observe the explanatory note before submittin	with relevant Commonwealth and State		
37623	(See para TN.8.46 <b>Fee:</b> \$233.55	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$175.20 85% = \$198.55			
	PAEDIATRIC GENITURINARY SURGERY				
	PATENT URAC	CHUS, excision of, on a person 10 years of age or	over. (Anaes.) (Assist.)		
37800 <b>Fee:</b> \$529.60 <b>Benefit:</b> 75% = \$397.20		<b>Benefit:</b> 75% = \$397.20			
	PATENT URAC	CHUS, excision of, when performed on a person u	ander 10 years of age (Anaes.) (Assist.)		
37801	Fee: \$688.50	<b>Benefit:</b> 75% = \$516.40			

T8. SUF	RGICAL OPERAT	IONS 5. UROLOGICAL	
	Fee: \$529.60	<b>Benefit:</b> 75% = \$397.20	
		D TESTIS, orchidopexy for, not being a service to which item 37807 applies, on a years of age (Anaes.) (Assist.)	
37804	Fee: \$688.50	<b>Benefit:</b> 75% = \$516.40	
		D TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, on a person 10 years of age or over (Anaes.) (Assist.)	
37806	<b>Fee:</b> \$611.90	<b>Benefit:</b> 75% = \$458.95 85% = \$527.20	
		D TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, on a person under 10 years of age (Anaes.) (Assist.)	
37807	Fee: \$795.50	<b>Benefit:</b> 75% = \$596.65 85% = \$710.80	
	UNDESCENDE (Assist.)	D TESTIS, revision orchidopexy for, on a person 10 years of age or over. (Anaes.)	
37809	Fee: \$611.90	<b>Benefit:</b> 75% = \$458.95	
	UNDESCENDE (Assist.)	D TESTIS, revision orchidopexy for, on a person under 10 years of age (Anaes.)	
37810	Fee: \$795.50	<b>Benefit:</b> 75% = \$596.65	
		TESTIS, exploration of groin for, not being a service associated with a service to which 306 and 37809 applies, on a person 10 years of age or over. (Anaes.) (Assist.)	
37812	Fee: \$564.90	<b>Benefit:</b> 75% = \$423.70	
		TESTIS, exploration of groin for, not being a service associated with a service to which 307 and 37810 applies, on a person under 10 years of age (Anaes.) (Assist.)	
37813	Fee: \$734.35	<b>Benefit:</b> 75% = \$550.80	
	HYPOSPADIAS (Anaes.)	6, examination under anaesthesia with erection test on a person 10 years of age or over.	
37815	Fee: \$94.25	<b>Benefit:</b> 75% = \$70.70	
	HYPOSPADIAS, examination under anaesthesia with erection test, on a person under 10 years of age (Anaes.)		
37816	Fee: \$122.55	<b>Benefit:</b> 75% = \$91.95	
	HYPOSPADIAS (Anaes.) (Assist.	s, glanuloplasty incorporating meatal advancement, on a person 10 years of age or over	
37818	Fee: \$499.30	<b>Benefit:</b> 75% = \$374.50 85% = \$424.45	
	HYPOSPADIAS (Anaes.) (Assist.	s, glanuloplasty incorporating meatal advancement, on a person under 10 years of age	
37819	Fee: \$649.10	<b>Benefit:</b> 75% = \$486.85 85% = \$564.40	
	HYPOSPADIAS	s, distal, 1 stage repair, on a person 10 years of age or over. (Anaes.) (Assist.)	
37821	Fee: \$846.45	<b>Benefit:</b> 75% = \$634.85	
5,021		5, distal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)	
27922			
37822	Fee: \$1,100.40	<b>Benefit:</b> 75% = \$825.30	

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICAI
	HYPOSPADIAS	, proximal, 1 stage repair on a person 10 years of age or over. (Anaes.) (Assist.)
37824	<b>Fee:</b> \$1,176.85	<b>Benefit:</b> 75% = \$882.65
	HYPOSPADIAS	, proximal, 1 stage repair, on a person under 10 years of age (Anaes.) (Assist.)
37825	Fee: \$1,529.90	<b>Benefit:</b> 75% = \$1147.45
		, staged repair, first stage, on a person 10 years of age or over. (Anaes.) (Assist.)
37827	Fee: \$542.15	<b>Benefit:</b> 75% = \$406.65
37027		, staged repair, first stage, on a person under 10 years of age (Anaes.) (Assist.)
37828	<b>Fee:</b> \$704.80	<b>Benefit:</b> 75% = \$528.60
37626		staged repair, second stage, on a person 10 years of age or over. (Anaes.) (Assist.)
27920	<b>Fee:</b> \$702.45	
37830		<b>Benefit:</b> 75% = \$526.85 85% = \$617.75 , staged repair, second stage, on a person under 10 years of age. (Anaes.) (Assist.)
37831	Fee: \$913.30	<b>Benefit:</b> 75% = \$685.00 85% = \$828.60
	(Assist.)	, repair of post-operative urethral fistula, on a person 10 years of age or over. (Anaes.)
37833	Fee: \$335.25	<b>Benefit:</b> 75% = \$251.45
	HYPOSPADIAS (Assist.)	, repair of post-operative urethral fistula, on a person under 10 years of age (Anaes.)
37834	Fee: \$435.80	<b>Benefit:</b> 75% = \$326.85
	EPISPADIAS, sta	aged repair, first stage (Anaes.) (Assist.)
37836	<b>Fee:</b> \$706.10	<b>Benefit:</b> 75% = \$529.60
	EPISPADIAS, sta	aged repair, second stage (Anaes.) (Assist.)
37839	Fee: \$800.20	<b>Benefit:</b> 75% = \$600.15
	EXSTROPHY O	F BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with
	or without ureteri	c reimplantation (Anaes.) (Assist.)
37842	Fee: \$1,553.55	<b>Benefit:</b> 75% = \$1165.20
	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.)	
37845	<b>Fee:</b> \$706.10	<b>Benefit:</b> 75% = \$529.60
	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.)	
37848	Fee: \$1,271.05	<b>Benefit:</b> 75% = \$953.30
		ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, with or without endoscopy (Anaes.) (Assist.)
37851	Fee: \$941.65	<b>Benefit:</b> 75% = \$706.25
2507	URETHRAL VA	LVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.)
37854		

T8. SUF	GICAL OPERATIONS	5. UROLOGICAL	
	<b>Fee:</b> \$372.30 <b>Benefit:</b> 75% = \$279.25		
T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC	
	Group T8. Surgical Operations		
	Subgroup 6. Cardio-Thoracic		
	CARDIOLOGY PROCEDURES		
	RIGHT HEART CATHETERISATION, with any one or more of the fodye dilution curves, cardiac output measurement by any method, shunt of (Anaes.)		
38200	<b>Fee:</b> \$452.55 <b>Benefit:</b> 75% = \$339.45 85% = \$384.70		
	LEFT HEART CATHETERISATION by percutaneous arterial puncture left ventricular puncture with any one or more of the following: fluorosc curves, cardiac output measurements by any method, shunt detection or	copy, oximetry, dye dilution	
38203	<b>Fee:</b> \$540.05 <b>Benefit:</b> 75% = \$405.05 85% = \$459.05		
	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETER or by any other procedure with any one or more of the following: fluorocurves, cardiac output measurements by any method, shunt detection or	scopy, oximetry, dye dilution	
38206	<b>Fee:</b> \$652.95 <b>Benefit:</b> 75% = \$489.75 85% = \$568.25		
	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigated 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular studies, not being a service associated with a service to which item 38212 or 38213 applies (A		
38209	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$838.35 <b>Benefit:</b> 75% = \$628.80  85% = \$753.65		
	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 inductionally inductionally 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.)		
38212	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$1,394.40 <b>Benefit:</b> 75% = \$1045.80 85% = \$1309.70		
	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - being a service associated with a service to which item 38209 or 38212 applies (Anaes.)		
38213	<b>Fee:</b> \$415.25 <b>Benefit:</b> 75% = \$311.45 85% = \$353.00		
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters a into the native coronary arteries, not being a service associated with a se 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 app	rvice to which item 38218,	
38215	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$360.60 <b>Benefit:</b> 75% = \$270.45  85% = \$306.55		
38218	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters a with right or left heart catheterisation or both, or aortography, not being service to which item 38215, 38220, 38222, 38225, 38228, 38231, 3823	a service associated with a	

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	applies (Anaes.)	
	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$540.75 <b>Benefit:</b> 75% = \$405.60 85% = \$459.65	
	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of cat material into free coronary graft(s) attached to the aorta (irrespective of the associated with a service to which item 38215, 38218, 38222, 3 38237, 38240 or 38246 applies (Anaes.)	he number of grafts), not being
38220	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$180.25 <b>Benefit:</b> 75% = \$135.20 85% = \$153.25	
	SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of car opaque material into direct internal mammary artery graft(s) to one or mode (irrespective of the number of grafts), not being a service associated with 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 approximately approximate	ore coronary arteries a a service to which item 38215,
38222	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$360.60 <b>Benefit:</b> 75% = \$270.45  85% = \$306.55	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters are into the native coronary arteries and placement of catheter(s) and injection coronary graft(s) attached to the aorta (irrespective of the number of graft associated with a service to which item 38215, 38218, 38220, 38222, 38238240 or 38246 applies (Anaes.)	on of opaque material into free its), not being a service
38225	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$540.85 <b>Benefit:</b> 75% = \$405.65  85% = \$459.75	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters are into the native coronary arteries and placement of catheter(s) and injectic internal mammary artery graft(s) to one or more coronary arteries (irrespond being a service associated with a service to which item 38215, 38218 38234, 38237, 38240 or 38246 applies (Anaes.)	on of opaque material into direct ective of the number of grafts),
38228	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$721.25 <b>Benefit:</b> 75% = \$540.95  85% = \$636.55	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters are into the native coronary arteries and placement of catheter(s) and injection free coronary graft(s) attached to the aorta (irrespective of the number of catheter(s) and injection of opaque material into direct internal mammary coronary arteries (irrespective of the number of grafts), not being a service which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 3	on of opaque material into the grafts), and placement of y artery graft(s) to one or more ce associated with a service to
38231	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$901.45 <b>Benefit:</b> 75% = \$676.10 85% = \$816.75	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters are with right or left heart catheterisation or both, or aortography and placement of opaque material into free coronary graft(s) attached to the aorta (irrespont being a service associated with a service to which item 38215, 38218 38231, 38237, 38240 or 38246 applies (Anaes.)	nent of catheter(s) and injection pective of the number of grafts),
38234	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$721.10 <b>Benefit:</b> 75% = \$540.85 85% = \$636.40	
38237	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters are with right or left heart catheterisation or both, or aortography and placement of catheters are with right or left heart catheterisation or both, or aortography and placement of catheters are with right or left heart catheterisation or both, or aortography and placement of catheters are with right or left heart catheters.	

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	of opaque material into direct internal mammary artery graft(s) to o (irrespective of the number of grafts), not being a service associated 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38240	I with a service to which item 38215,
	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$901.40 <b>Benefit:</b> 75% = \$676.05  85% = \$816.70	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathet with right or left heart catheterisation or both, or aortography and pl of opaque material into free coronary graft(s) attached to the aorta (and placement of catheter(s) and injection of opaque material into d graft(s) to one or more coronary arteries (irrespective of the number associated with a service to which item 38215, 38218, 38220, 3822, 38237 or 38246 applies (Anaes.)	lacement of catheter(s) and injection irrespective of the number of grafts) lirect internal mammary artery of grafts), not being a service
38240	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$1,081.65 <b>Benefit:</b> 75% = \$811.25 85% = \$996.95	
	USE OF A CORONARY PRESSURE WIRE during selective coron fractional flow reserve (FFR) and coronary flow reserve (CFR) in or artery or graft lesions (stenosis of 30-70%), to determine whether rewhere previous stress testing has either not been performed or the reserved.	ne or more intermediate coronary evascularisation should be performed
38241	<b>Fee:</b> \$477.20 <b>Benefit:</b> 75% = \$357.90 85% = \$405.65	
	PLACEMENT OF CATHETER(S) and injection of opaque material graft(s) prior to any coronary interventional procedure, not being a which item 38246 applies (Anaes.)	
38243	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$450.70 <b>Benefit:</b> 75% = \$338.05 85% = \$383.10	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of cathet with right or left heart catheterisation or both, or aortography follow any coronary interventional procedure, not being a service associate 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237,	yed by placement of catheters prior to ed with a service to which item
38246	(See para TN.8.52 of explanatory notes to this Category) <b>Fee:</b> \$901.40 <b>Benefit:</b> 75% = \$676.05  85% = \$816.70	
	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE,	insertion of (Anaes.)
38256	<b>Fee:</b> \$271.55 <b>Benefit:</b> 75% = \$203.70 85% = \$230.85	
	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPT catheterisations before and after balloon dilatation (Anaes.) (Assist.	
38270	<b>Fee:</b> \$926.90 <b>Benefit:</b> 75% = \$695.20 85% = \$842.20	
	ATRIAL SEPTAL DEFECT closure, with septal occluder or other approach (Anaes.) (Assist.)	similar device, by transcatheter
38272	<b>Fee:</b> \$926.90 <b>Benefit:</b> 75% = \$695.20 85% = \$842.20	
	Patent ductus arteriosus, transcatheter closure of, including cardiac associated with the service (Anaes.) (Assist.)	catheterisation and any imaging
38273	<b>Fee:</b> \$926.90 <b>Benefit:</b> 75% = \$695.20	
38274	Ventricular septal defect, transcatheter closure of, with imaging and	cardiac catheterisation (Anaes.)

T8. SUF	RGICAL OPERAT	IONS	6. CARDIO-THORACIC
	(Assist.)		
	Fee: \$926.90	<b>Benefit:</b> 75% = \$695.20	
	MYOCARDIAI	BIOPSY, by cardiac catheteris	sation (Anaes.)
38275	Fee: \$302.95	<b>Benefit:</b> 75% = \$227.25 88	35% = \$257.55
	practitioner, for	stroke prevention in a patient w to life-long oral anticoagulation	e, and cardiac catheterisation performed by the same who has non-valvular atrial fibrillation and a on therapy, and is at increased risk of thromboembolism
		e (whether of an ischaemic or ur systemic embolism; or	nknown type), transient ischaemic attack or non-central
	(b) at least 2 of t	he following risk factors:	
	(i) an age of 65	years or more;	
	(ii) hypertension	;	
	(iii) diabetes me	llitus;	
	(iv) heart failure	or left ventricular ejection fract	etion of 35% or less (or both);
	(v) vascular dise	ase (prior myocardial infarction	n, peripheral artery disease or aortic plaque)
	(Anaes.) (Assis	st.)	
38276	(See para TN.8.13 <b>Fee:</b> \$926.90	2 of explanatory notes to this Categ <b>Benefit:</b> 75% = \$695.20	egory)
		E ECG LOOP RECORDER, instruction in the second seco	sertion of, for diagnosis of primary disorder in patients
	- a diagnosis	s has not been achieved through	h all other available cardiac investigations; and
	- a neuroger	nic cause is not suspected; and	
	- it has been risk of sudden ca	-	es not have structural heart disease associated with a high
	including initial	programming and testing, as an	n admitted patient in an approved hospital (Anaes.)
38285	(See para TN.8.61 <b>Fee:</b> \$196.00	of explanatory notes to this Categoral Benefit: 75% = \$147.00 8:	
	IMPLANTABLE (Anaes.)	E ECG LOOP RECORDER, re	emoval of, as an admitted patient in an approved hospital
38286	Fee: \$176.55	<b>Benefit:</b> 75% = \$132.45 83	35% = \$150.10
	Implantable loop	recorder, insertion of, for diag	gnosis of atrial fibrillation, if:
20200	(a) the patient to undetermined so		has been diagnosed as having had an embolic stroke of
38288			

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
	(b) the bases of the diagnosis included the following:	
	(i) the medical history of the patient;	
	(ii) physical examination;	
	(iii) brain and carotid imaging;	
	(iv) cardiac imaging;	
	(v) surface ECG testing including 24-hour Holter monitoring; and	
	(c) atrial fibrillation is suspected; and	
	(d) the patient:	
	(i) does not have a permanent indication for oral anticoagulants; or	
	(ii) does not have a permanent oral anticoagulants contraindication;	
	(ii) does not have a permanent of a anaeologicanis communication,	
	including initial programming and testing	
	(Anaes.)	
	<b>Fee:</b> \$196.00 <b>Benefit:</b> 75% = \$147.00 85% = \$166.60 CATHETER BASED ARRHYTHMIA ABLATION	AI
	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation proce	
	chamber (Anaes.) (Assist.)	dure involving 1 autai
38287	<b>Fee:</b> \$2,132.05 <b>Benefit:</b> 75% = \$1599.05 85% = \$2047.35	
	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation proce	
	chambers and including curative procedures for atrial fibrillation (Anaes.) (	Assist.)
38290	<b>Fee:</b> \$2,714.70 <b>Benefit:</b> 75% = \$2036.05	
	VENTRICULAR ARRHYTHMIA with mapping and ablation, including a electrophysiological studies performed on the same day (Anaes.) (Assist.)	ll associated
38293	<b>Fee:</b> \$2,913.95 <b>Benefit:</b> 75% = \$2185.50 85% = \$2829.25	
	ENDOVASCULAR INTERVENTIONAL PROCEDU	IRES
	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, per	cutaneous or by open
	exposure, excluding associated radiological services or preparation, and exc (Assist.)	
38300	<b>Fee:</b> \$523.60 <b>Benefit:</b> 75% = \$392.70 85% = \$445.10	
	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary open exposure, excluding associated radiological services or preparation an (Anaes.) (Assist.)	
38303	<b>Fee:</b> \$671.35 <b>Benefit:</b> 75% = \$503.55 85% = \$586.65	
38306	Transluminal insertion of stent or stents into one occlusional site, including of coronary artery, percutaneous or by open exposure, excluding associated	

T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC		
	radiological preparation and after-care (Anaes.) (Assist.)			
	(See para TN.8.62 of explanatory notes to this Category) <b>Fee:</b> \$774.55 <b>Benefit:</b> 75% = \$580.95  85% = \$689.85			
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOM including balloon angioplasty with no stent insertion, where:	Y of 1 coronary artery,		
	- 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 after	tercare (Anaes.) (Assist.)		
38309	(See para TN.8.41 of explanatory notes to this Category) <b>Fee:</b> \$899.60 <b>Benefit:</b> 75% = \$674.70 85% = \$814.90			
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOM including balloon angioplasty with insertion of 1 or more stents, where:	Y of 1 coronary artery,		
	- 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.)			
38312	(See para TN.8.41 of explanatory notes to this Category) <b>Fee:</b> \$1,150.45 <b>Benefit:</b> 75% = \$862.85 85% = \$1065.75			
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOM artery, including balloon angioplasty with no stent insertion, where:	Y of more than 1 coronary		
	- no lesion of the coronary arteries has been stented; and			
	- each lesion of the coronary arteries is complex and heavily calcified; an	ad		
	- balloon angioplasty with or without stenting is not suitable;			
	excluding associated radiological services or preparation, and excluding af	tercare (Anaes.) (Assist.)		
38315	(See para TN.8.41 of explanatory notes to this Category) <b>Fee:</b> \$1,235.30 <b>Benefit:</b> 75% = \$926.50 85% = \$1150.60			
	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOM artery, including balloon angioplasty, with insertion of 1 or more stents, when the stents is a second control of 1 or more stents.			
	- no lesion of the coronary arteries has been stented; and			
	- each lesion of the coronary arteries is complex and heavily calcified; an	ad		
	- balloon angioplasty with or without stenting is not suitable,			
	excluding associated radiological services or preparation, and excluding after	tercare (Anaes.) (Assist.)		
38318	(See para TN.8.41 of explanatory notes to this Category)			

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC			
	<b>Fee:</b> \$1,611.75 <b>Benefit:</b> 75% = \$1208.85 85% = \$13	527.05			
	MISCELLANEOUS CARDIAC PROCEDURES				
	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.)				
38350	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$648.85 <b>Benefit:</b> 75% = \$486.65				
	PERMANENT CARDIAC PACEMAKER, insertion, representation therapy, including cardiac electrophysimplantation (Anaes.)				
38353	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$259.55 <b>Benefit:</b> 75% = \$194.70				
	DUAL CHAMBER PERMANENT TRANSVENOUS E replacement of, including cardiac electrophysiological se (Anaes.)				
38356	(See para TN.8.60 of explanatory notes to this Category) <b>Fee:</b> \$850.75 <b>Benefit:</b> 75% = \$638.10				
	Extraction of chronically implanted transvenous pacing of method where the leads have been in situ for greater than stylets, snares and/or extraction sheaths in a facility when with item 61109 or 60509 (Anaes.) (Assist.)	six months and require removal with locking			
38358	(See para TN.8.64 of explanatory notes to this Category) <b>Fee:</b> \$2,913.95 <b>Benefit:</b> 75% = \$2185.50				
	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.)				
38359	<b>Fee:</b> \$135.70 <b>Benefit:</b> 75% = \$101.80 85% = \$115.35				
	INTRA-AORTIC BALLOON PUMP, percutaneous inse	ertion of (Anaes.)			
38362	<b>Fee:</b> \$391.10 <b>Benefit:</b> 75% = \$293.35 85% = \$333	2.45			
	Permanent cardiac synchronisation device (including a cadefibrillation), insertion, removal or replacement of, for a	ardiac synchronisation device that is capable of			
	(a) has:				
	(i) moderate to severe chronic heart failure (New Y despite optimised medical therapy; and	ork Heart Association (NYHA) class III or IV)			
	(ii) sinus rhythm; and				
	(iii) a left ventricular ejection fraction of less than o	or equal to 35%; and			
	(iv) a QRS duration greater than or equal to 120 ms	s; or			
	(b) satisfied the requirements mentioned in paragraph (resynchronisation therapy device and transvenous lef				
38365	(See para TN.8.63 of explanatory notes to this Category) <b>Fee:</b> \$259.55 <b>Benefit:</b> 75% = \$194.70				
38368	Permanent transvenous left ventricular electrode, insertic	on, removal or replacement of through the			

## **T8. SURGICAL OPERATIONS**

## 6. CARDIO-THORACIC

coronary sinus, for the purpose of cardiac resynchronisation therapy, including right heart catheterisation and any associated venogram of left ventricular veins, other than a service associated with a service to which item 35200 or 38200 applies, for a patient who:

- (a) has:
  - (i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV) despite optimised medical therapy; and
  - (ii) sinus rhythm; and
  - (iii) a left ventricular ejection fraction of less than or equal to 35%; and
  - (iv) a QRS duration greater than or equal to 120 ms; or
- (b) has:
  - (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and
  - (ii) sinus rhythm; and
  - (iii) a left ventricular ejection fraction of less than or equal to 35%; and
  - (iv) a QRS duration greater than or equal to 150 ms; or
- (c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode (Anaes.)

(See para TN.8.63 of explanatory notes to this Category)

**Fee:** \$1,244.20 **Benefit:** 75% = \$933.15

Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who:

- (a) has:
  - (i) moderate to severe chronic heart failure (New York Heart Association ((NYHA) class III or IV) despite optimised medical therapy; and
  - (ii) sinus rhythm; and
  - (iii) a left ventricular ejection fraction of less than or equal to 35%; and
  - (iv) a QRS duration greater than or equal to 120 ms; or
- (b) has:
  - (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and
  - (ii) sinus rhythm; and
  - (iii) a left ventricular ejection fraction of less than or equal to 35%; and
  - (iv) a QRS duration greater than or equal to 150 ms (Anaes.)

38371 (See para TN.8.65 of explanatory notes to this Category)

T8. SU	RGICAL OPERATIONS		6. CARDIO-THORACIC	
	Fee: \$292.45	<b>Benefit:</b> 75% = \$219.35		
			of patches for, or insertion of transvenous endocardial on of sudden cardiac death in:	
			action of less than or equal to 30% at least one month after received optimised medical therapy; or	
	and a left ver		ted with mild to moderate symptoms (NYHA II and III) than or equal to 35% when the patient has received	
	Not being a serv	vice associated with a service	to which item 38213 applies (Anaes.) (Assist.)	
38384	Fee: \$1,069.50	<b>Benefit:</b> 75% = \$802.15	85% = \$984.80	
	AUTOMATIC I of sudden cardia		TOR, insertion or replacement of for, primary prevention	
			action of less than or equal to 30% at least one month after received optimised medical therapy; or	
	and a left ver		ted with mild to moderate symptoms (NYHA II and III) than or equal to 35% when the patient has received	
	_	vice associated with a service chronisation therapy (Anaes.)	to which item 38213 applies, not for defibrillators capable (Assist.)	
38387	Fee: \$292.45	<b>Benefit:</b> 75% = \$219.35	85% = \$248.60	
	defibrillation ele	ectrodes for - not for patients	of patches for, or insertion of transvenous endocardial with heart failure or as primary prevention for tachycardia with a service to which item 38213 applies (Anaes.)	
38390	<b>Fee:</b> \$1,069.50	<b>Benefit:</b> 75% = \$802.15	85% = \$984.80	
	heart failure or a		TOR, insertion or replacement of for - not for patients with hycardia arrhythmias. Not being a service associated with a (Assist.)	
38393	Fee: \$292.45	<b>Benefit:</b> 75% = \$219.35	85% = \$248.60	

T8. SUF	RGICAL OPERATION	ONS 6. CARDIO-THORACIC	
	EMPYEMA, radio	al operation for, involving resection of rib (Anaes.) (Assist.)	
38415	<b>Fee:</b> \$405.75	<b>Benefit:</b> 75% = \$304.35 85% = \$344.90	
	THORACOTOMY	, exploratory, with or without biopsy (Anaes.) (Assist.)	
38418	<b>Fee:</b> \$973.75	<b>Benefit:</b> 75% = \$730.35	
	THORACOTOMY	, with pulmonary decortication (Anaes.) (Assist.)	
38421	<b>Fee:</b> \$1,556.50	<b>Benefit:</b> 75% = \$1167.40	
	THORACOTOMY (Anaes.) (Assist.)	y, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts	
38424	Fee: \$973.75	<b>Benefit:</b> 75% = \$730.35	
	THORACOPLAS	ΓY (complete) - 3 or more ribs (Anaes.) (Assist.)	
38427	<b>Fee:</b> \$1,202.35	<b>Benefit:</b> 75% = \$901.80	
	THORACOPLAS	ΓΥ (in stages) each stage (Anaes.) (Assist.)	
38430	<b>Fee:</b> \$619.65	<b>Benefit:</b> 75% = \$464.75	
		Y, with or without division of pleural adhesions, including insertion of intercostal essary, with or without biopsy (Anaes.)	
38436	Fee: \$253.75	<b>Benefit:</b> 75% = \$190.35	
		MY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a em 38418 applies (Anaes.) (Assist.)	
38438	<b>Fee:</b> \$1,556.50	<b>Benefit:</b> 75% = \$1167.40	
	LUNG, wedge res	ection of (Anaes.) (Assist.)	
38440	<b>Fee:</b> \$1,165.55	<b>Benefit:</b> 75% = \$874.20	
		CTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, rnal mediastinal node dissection (Anaes.) (Assist.)	
38441	Fee: \$1,844.25	<b>Benefit:</b> 75% = \$1383.20	
	THORACOTOMY	Y or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.)	
38446	<b>Fee:</b> \$1,202.35	<b>Benefit:</b> 75% = \$901.80	
	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.)		
38447	Fee: \$1,556.50	<b>Benefit:</b> 75% = \$1167.40	
	MEDIASTINUM,	cervical exploration of, with or without biopsy (Anaes.) (Assist.)	
38448	Fee: \$368.85	<b>Benefit:</b> 75% = \$276.65	
	PERICARDIECTO (Anaes.) (Assist.)	DMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass	
38449	<b>Fee:</b> \$2,177.50	<b>Benefit:</b> 75% = \$1633.15	
38450	PERICARDIUM,	transthoracic open surgical drainage of (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATI	ONS	6. CARDIO-THORACIC
	Fee: \$870.35	<b>Benefit:</b> 75% = \$652.80	
	PERICARDIUM	, subxiphoid open surgical drainage of (Anae	s.) (Assist.)
38452	Fee: \$582.90	<b>Benefit:</b> 75% = \$437.20	
	TRACHEAL exc	ision and repair without cardiopulmonary by	pass (Anaes.) (Assist.)
38453	Fee: \$1,748.45	<b>Benefit:</b> 75% = \$1311.35	
		CISION AND REPAIR OF, with cardiopulm	nonary bypass (Anaes.) (Assist.)
38455	Fee: \$2,364.95	<b>Benefit:</b> 75% = \$1773.75	
	INTRATHORAC	CIC OPERATION on heart, lungs, great vesse on more than 1 of those organs, not being a se	
38456	Fee: \$1,556.50	<b>Benefit:</b> 75% = \$1167.40	
	PECTUS EXCA	VATUM or PECTUS CARINATUM, repair	or radical correction of (Anaes.) (Assist.)
38457	Fee: \$1,453.15	<b>Benefit:</b> 75% = \$1089.90	
		VATUM, repair of, with implantation of subc	cutaneous prosthesis (Anaes.) (Assist.)
38458	<b>Fee:</b> \$774.55	<b>Benefit:</b> 75% = \$580.95	
30430		E OR WIRES, removal of (Anaes.)	
20.440			
38460	Fee: \$279.80 Benefit: 75% = \$209.85  STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes		
	STERNOTOMT		pening of the mediastinum (Anaes.)
38462	Fee: \$331.65	<b>Benefit:</b> 75% = \$248.75	
		WOUND, debridement of, involving curettage but not involving reopening of the mediasting	
38464	Fee: \$360.50	<b>Benefit:</b> 75% = \$270.40	
	_	peration on, for dehiscence or infection involv (Anaes.) (Assist.)	ring reopening of the mediastinum, with or
38466	<b>Fee:</b> \$973.35	<b>Benefit:</b> 75% = \$730.05	
	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.)		of, involving muscle advancement flaps
38468	Fee: \$1,499.75	<b>Benefit:</b> 75% = \$1124.85	
		MEDIASTINUM, reoperation for infection tum (Anaes.) (Assist.)	of, involving muscle advancement flaps
38469	Fee: \$1,748.45	<b>Benefit:</b> 75% = \$1311.35	
		CARDIAC SURGERY PROC	EDURES
	PERMANENT N (Assist.)	IYOCARDIAL ELECTRODE, insertion of, I	by thoracotomy or sternotomy (Anaes.)
38470	(See para TN.8.67 <b>Fee:</b> \$973.75	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$730.35	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THOR	ACIC	
	PERMANENT PACEMAKER ELECTRODE, insertion by open surgical approach (Anaes.) (Assis	t.)	
38473	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$582.90 <b>Benefit:</b> 75% = \$437.20		
	VALVULAR PROCEDURES		
	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service which item 38480 or 38481 applies (Anaes.) (Assist.)	to	
38475	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$845.05 <b>Benefit:</b> 75% = \$633.80		
	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.)		
38477	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,035.40 <b>Benefit:</b> 75% = \$1526.55		
	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38 (Anaes.) (Assist.)	481	
38478	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$985.95 <b>Benefit:</b> 75% = \$739.50		
	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.)		
38480	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,035.40 <b>Benefit:</b> 75% = \$1526.55		
	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.)		
38481	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,317.15 <b>Benefit:</b> 75% = \$1737.90		
	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.)		
38483	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,748.45 <b>Benefit:</b> 75% = \$1311.35		
	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with surgery (Anaes.) (Assist.)	valve	
38485	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$830.15 <b>Benefit:</b> 75% = \$622.65		
	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)		
38487	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,748.45 <b>Benefit:</b> 75% = \$1311.35		
	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.)		
38488	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,940.15 <b>Benefit:</b> 75% = \$1455.15		
	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.)	aft	
38489	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,307.40 <b>Benefit:</b> 75% = \$1730.55		

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC		
	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation tricuspid valve replacement (Anaes.) (Assist.)	n of, associated with mitral and		
38490	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$563.40 <b>Benefit:</b> 75% = \$422.55			
	OPERATIVE MANAGEMENT of acute infective endocarditis, in association (Anaes.) (Assist.)	ociation with heart valve surgery		
38493	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,988.90 <b>Benefit:</b> 75% = \$1491.70			
	TAVI, for the treatment of symptomatic severe aortic stenosis, perform unless transfemoral delivery is contraindicated or not feasible, in a TAVI a TAVI Practitioner – includes all intraoperative diagnostic imaging the upon the TAVI Patient.	VI Hospital on a TAVI Patient by		
	(Not payable more than once per patient in a five year period.) (Anaes.)	) (Assist.)		
38495	(See para AN.33.1, TN.8.135 of explanatory notes to this Category) <b>Fee:</b> \$1,455.10 <b>Benefit:</b> 75% = \$1091.35 85% = \$1370.40			
	SURGERY FOR ISCHAEMIC HEART DISI	EASE		
	ARTERY HARVESTING (other than internal mammary), for coronary	artery bypass (Anaes.) (Assist.)		
38496	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$633.95 <b>Benefit:</b> 75% = \$475.50			
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using only, including harvesting of vein graft material where performed, not be service to which items 38498, 38500, 38501, 38503 or 38504 apply (An	being a service asociated with a		
38497	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,080.35 <b>Benefit:</b> 75% = \$1560.30			
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, per bypass, using saphenous vein graft or grafts only, including harvesting performed, either via a median sternotomy or other minimally invasive perfusionist is present, not being a service associated with a service to \$38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.)	of vein graft material where technique and where a stand-by		
38498	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,080.35 <b>Benefit:</b> 75% = \$1560.30			
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using without vein graft or grafts, including harvesting of internal mammary where performed, not being a service associated with a service to which 38503 or 38504 apply (Anaes.) (Assist.)	artery or vein graft material		
38500	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,235.20 <b>Benefit:</b> 75% = \$1676.40			
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, per bypass, using single arterial graft, with or without vein graft or grafts, i mammary artery or vein graft material where performed, either via a m minimally invasive technique and where a stand-by perfusionist is pres with a service to which items 38497, 38498, 38500, 38503, 38504 or 3	ncluding harvesting of internal edian sternotomy or other ent, not being a service associated		
38501	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,235.20 <b>Benefit:</b> 75% = \$1676.40			

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 without vein graft or grafts, including harvesting of internal mammary art where performed, not being a service associated with a service to which it 38501 or 38504 apply (Anaes.) (Assist.)	ery or vein graft material
38503	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,426.90 <b>Benefit:</b> 75% = \$1820.20	
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, perforbypass, using 2 or more arterial grafts, with or without vein graft or grafts internal mammary artery or vein graft material where performed, either viminimally invasive technique and where a stand-by perfusionist is presen with a service to which items 38497, 38498, 38500, 38501, 38503 or 3860	s, including harvesting of ia a median sternotomy or other t, not being a service associated
38504	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,426.90 <b>Benefit:</b> 75% = \$1820.20	
	CORONARY ENDARTERECTOMY, by open operation, including repa each vessel (Anaes.) (Assist.)	ir with 1 or more patch grafts,
38505	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$281.70 <b>Benefit:</b> 75% = \$211.30	
	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.)	
38506	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,652.25 <b>Benefit:</b> 75% = \$1239.20	
	LEFT VENTRICULAR ANEURYSM resection with primary repair (Ana	aes.) (Assist.)
38507	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,939.75 <b>Benefit:</b> 75% = \$1454.85	
	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction (Assist.)	n of the left ventricle (Anaes.)
20.500	(See para TN.8.67 of explanatory notes to this Category)	
38508	Fee: \$2,426.90 Benefit: 75% = \$1820.20  ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.)	(Assist.)
	(See para TN.8.67 of explanatory notes to this Category)	( )
38509	Fee: \$2,426.90 Benefit: 75% = \$1820.20	
	ARRHYTHMIA SURGERY	
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.)	re on atrioventricular node or
38512	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,132.05 <b>Benefit:</b> 75% = \$1599.05	
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure perinodal tissues involving both atrial chambers and including curative su (Anaes.) (Assist.)	
38515	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,714.70 <b>Benefit:</b> 75% = \$2036.05	
20212	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, w. (Anaes.) (Assist.)	ith or without aneurysmeotomy
38518		

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACI
	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,913.95 <b>Benefit:</b> 75% = \$2185.50
	PROCEDURES ON THORACIC AORTA
	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repa or coronary artery implantation (Anaes.) (Assist.)
38550	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,180.50 <b>Benefit:</b> 75% = \$1635.40
	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)
38553	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,763.25 <b>Benefit:</b> 75% = \$2072.45
	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)
38556	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$3,154.40 <b>Benefit:</b> 75% = \$2365.80
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.)
38559	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,571.50 <b>Benefit:</b> 75% = \$1928.65
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)
38562	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$3,154.40 <b>Benefit:</b> 75% = \$2365.80
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)
38565	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$3,537.95 <b>Benefit:</b> 75% = \$2653.50
	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass, by open exposure, percutaneous or endovascular means (Anaes.) (Assist.)
38568	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,892.75 <b>Benefit:</b> 75% = \$1419.60
	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypas (Anaes.) (Assist.)
38571	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,084.60 <b>Benefit:</b> 75% = \$1563.45
	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.)
38572	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,018.85 <b>Benefit:</b> 75% = \$1514.15
	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.)
38577	(See para TN.8.67 of explanatory notes to this Category)

T8. SUF	RGICAL OPERAT	TIONS	6. CARDIO-THORACIC		
	Fee: \$563.40	<b>Benefit:</b> 75% = \$422.55			
		TECHNIQUES FOR PRE	SERVATION OF ARRESTED HEART		
		N of the coronary sinus for, ar ardioplegia, including pressure	d supervision of, the retrograde administration of blood or monitoring (Assist.)		
38588	(See para TN.8.67 <b>Fee:</b> \$422.70	of explanatory notes to this Cate; <b>Benefit:</b> 75% = \$317.05	gory)		
		CIRCULATORY	SUPPORT PROCEDURES		
			onary bypass excluding post-operative management, not ich another item in this Subgroup applies (Anaes.)		
38600	(See para TN.8.67 <b>Fee:</b> \$1,556.50	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$1167.40	gory)		
	PERIPHERAL ( (Anaes.) (Assist	-	lmonary bypass excluding post-operative management		
38603	(See para TN.8.67 <b>Fee:</b> \$973.75	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$730.35	gory)		
	INTRA-AORTI	C BALLOON PUMP, insertio	n of, by arteriotomy (Anaes.) (Assist.)		
38609	(See para TN.8.67 <b>Fee:</b> \$486.80	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$365.10	gory)		
	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.)				
38612	(See para TN.8.67 <b>Fee:</b> \$545.70	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$409.30			
	INTRA-AORTI (Assist.)	C BALLOON PUMP, remova	l of, with closure of artery by patch graft (Anaes.)		
38613	(See para TN.8.67 <b>Fee:</b> \$684.85	of explanatory notes to this Cate Benefit: 75% = \$513.65	gory)		
	Insertion of a lef	ft or right ventricular assist dev	rice, for use as:		
	(a) a bridge to	cardiac transplantation in patie	ents with refractory heart failure who are:		
	(i) currently on a heart transplant waiting list, or				
	(ii) expected the ventricular	d to be suitable candidates for	cardiac transplantation following a period of support on		
	assist devic	ee; or			
	(b) acute post	cardiotomy support for failure	to wean from cardiopulmonary transplantation; or		
	(c) cardio-resp support of less th		ac failure which is likely to recover with short term		
	weeks;				
38615			ventricular assist device as destination therapy in the are not expected to be suitable candidates for cardiac		

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC		
	transplantation (Anaes.) (Assist.)			
	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,556.50 <b>Benefit:</b> 75% = \$1167.40			
	Insertion of a left and right ventricular assist device, for use as:			
	(a) a bridge to cardiac transplantation in patients with refractory heart f	failure who are:		
	(i) currently on a heart transplant waiting list, or			
	(ii) expected to be suitable candidates for cardiac transplantation foll the ventricular	lowing a period of support on		
	assist device; or			
	(b) acute post cardiotomy support for failure to wean from cardiopulmo	onary transplantation; or		
	(c) cardio-respiratory support for acute cardiac failure which is likely to support of less than 6	o recover with short term		
	weeks;			
	not being a service associated with the use of a ventricular assist device a management of patients with heart failure who are not expected to be sui transplantation (Anaes.) (Assist.)	1.0		
38618	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,940.15 <b>Benefit:</b> 75% = \$1455.15			
	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as a (Anaes.) (Assist.)	n independent procedure		
38621	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$774.55 <b>Benefit:</b> 75% = \$580.95			
	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as (Anaes.) (Assist.)	an independent procedure		
38624	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$870.35 <b>Benefit:</b> 75% = \$652.80			
	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR DEVICE CANNULAE, adjustment and re-positioning of, by open opera these devices (Anaes.) (Assist.)			
38627	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$680.30 <b>Benefit:</b> 75% = \$510.25			
	RE-OPERATION			
	PATENT DISEASED coronary artery bypass vein graft or grafts, dissect oversewing of (Anaes.) (Assist.)	tion, disconnection and		
38637	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$563.40 <b>Benefit:</b> 75% = \$422.55			
	RE-OPERATION via median sternotomy, for any procedure, including a where the time taken to divide the adhesions is 45 minutes or less (Anaes			
38640	(See para TN.8.69, TN.8.67 of explanatory notes to this Category)			

T8. SU	URGICAL OPERATIONS		6. CARDIO-THORACIC	
	Fee: \$973.75	<b>Benefit:</b> 75% = \$730.35		
		MISCELLANEOUS CARD	OTHORACIC SURGICAL PROCEDURES	
		MY OR STERNOTOMY invaceeds 45 minutes (Anaes.) (	volving division of adhesions where the time taken to divide Assist.)	
38643	(See para TN.8.67 <b>Fee:</b> \$1,084.50	7 of explanatory notes to this Ca <b>Benefit:</b> 75% = \$813.40	tegory)	
		MY OR STERNOTOMY inv hesions exceeds 2 hours (Ana	volving division of extensive adhesions where the time taken nes.) (Assist.)	
38647	(See para TN.8.67 <b>Fee:</b> \$2,168.65	7 of explanatory notes to this Ca <b>Benefit:</b> 75% = \$1626.50		
	MYOMECTON	MY or MYOTOMY for hyper	trophic obstructive cardiomyopathy (Anaes.) (Assist.)	
38650	(See para TN.8.67 <b>Fee:</b> \$1,940.15	7 of explanatory notes to this Ca <b>Benefit:</b> 75% = \$1455.13	- ·	
	OPEN HEART (Assist.)	SURGERY, not being a serv	ice to which another item in this Group applies (Anaes.)	
38653	(See para TN.8.67 <b>Fee:</b> \$1,940.15	7 of explanatory notes to this Ca <b>Benefit:</b> 75% = \$1455.15		
		ventricular electrode, insertio iac resynchronisation therapy	n, removal or replacement of via open thoracotomy, for the , for a patient who:	
	(a) has:			
		ate to severe chronic heart fail optimised medical therapy; an	ure (New York Heart Association (NYHA) class III or IV)	
	(ii) sinus r	hythm; and		
	(iii) a left	ventricular ejection fraction of	of less than or equal to 35%; and	
	(iv) a QRS	S duration greater than or equ	al to 120 ms; or	
	(b) has:			
(i) mild chronic heart fail medical therapy; and			k Heart Association (NYHA) class II) despite optimised	
	(ii) sinus r	hythm; and		
	(iii) a left	ventricular ejection fraction of	of less than or equal to 35%; and	
	(iv) a QRS	S duration greater than or equ	al to 150 ms; or	
			paragraph (a) or (b) immediately before the insertion of a and transvenous left ventricle electrode	
	(Anaes.) (Assist	t.)		
38654	(See para TN.8.63 <b>Fee:</b> \$1,244.20	3, TN.8.67 of explanatory notes <b>Benefit:</b> 75% = \$933.15	to this Category)	

T8. SUF	GICAL OPERATIONS	6. CARDIO-THORACIC
	THORACOTOMY or median sternotomy for post-operative bleed	ing (Anaes.) (Assist.)
38656	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$973.75 <b>Benefit:</b> 75% = \$730.35	
	CARDIAC TUMOURS	
	CARDIAC TUMOUR, excision of, involving the wall of the atriur or conduit reconstruction (Anaes.) (Assist.)	n or inter-atrial septum, without patch
38670	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,939.75 <b>Benefit:</b> 75% = \$1454.85	
	CARDIAC TUMOUR, excision of, involving the wall of the atriur reconstruction with patch or conduit (Anaes.) (Assist.)	n or inter-atrial septum, requiring
38673	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,183.25 <b>Benefit:</b> 75% = \$1637.45	
	CARDIAC TUMOUR arising from ventricular myocardium, partia (Assist.)	al thickness excision of (Anaes.)
38677	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,042.50 <b>Benefit:</b> 75% = \$1531.90	
	CARDIAC TUMOUR arising from ventricular myocardium, full the or reconstruction (Anaes.) (Assist.)	nickness excision of including repair
38680	(See para TN.8.70 of explanatory notes to this Category) <b>Fee:</b> \$2,422.70 <b>Benefit:</b> 75% = \$1817.05 85% = \$2338.00	
	CONGENITAL CARDIAC SURG	ERY
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other sing without cardiopulmonary bypass, for congenital heart disease (Ana	
38700	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,084.50 <b>Benefit:</b> 75% = \$813.40	
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other sing with cardiopulmonary bypass, for congenital heart disease (Anaes.)	
38703	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,954.90 <b>Benefit:</b> 75% = \$1466.20	
	AORTA, anastomosis or repair of, without cardiopulmonary bypas (Anaes.) (Assist.)	s, for congenital heart disease
38706	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,851.55 <b>Benefit:</b> 75% = \$1388.70	
	AORTA, anastomosis or repair of, with cardiopulmonary bypass, f (Assist.)	or congenital heart disease (Anaes.)
38709	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,168.65 <b>Benefit:</b> 75% = \$1626.50	
	AORTIC INTERRUPTION, repair of, for congenital heart disease	(Anaes.) (Assist.)
38712	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,604.15 <b>Benefit:</b> 75% = \$1953.15	
	MAIN PULMONARY ARTERY, banding, debanding or repair of	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIC
	congenital heart disease (Anaes.) (Assist.)
	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,733.60 <b>Benefit:</b> 75% = \$1300.20
	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38718	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,168.65 <b>Benefit:</b> 75% = \$1626.50
	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38721	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,519.75 <b>Benefit:</b> 75% = \$1139.85
	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38724	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,168.65 <b>Benefit:</b> 75% = \$1626.50
	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.)
38727	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,519.75 <b>Benefit:</b> 75% = \$1139.85
	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.)
38730	<b>Fee:</b> \$2,168.65 <b>Benefit:</b> 75% = \$1626.50
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38733	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,519.75 <b>Benefit:</b> 75% = \$1139.85
	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38736	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$2,168.65 <b>Benefit:</b> 75% = \$1626.50
	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38739	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,954.90 <b>Benefit:</b> 75% = \$1466.20
	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.)
38742	(See para TN.8.67 of explanatory notes to this Category) <b>Fee:</b> \$1,954.90 <b>Benefit:</b> 75% = \$1466.20
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATIO	NS	6. CARDIO-THORACIC
	(See para TN.8.67 of <b>Fee:</b> \$2,168.65	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1626.50	
	VENTRICULAR S	EPTECTOMY, for congenital heart disease (Ana-	es.) (Assist.)
38748	(See para TN.8.67 of <b>Fee:</b> \$2,168.65	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1626.50	
	Ventricular septal d	lefect, closure by direct suture or patch (Anaes.) (A	Assist.)
38751	(See para TN.8.67 of <b>Fee:</b> \$2,168.65	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1626.50	
	INTRAVENTRICU (Assist.)	JLAR BAFFLE OR CONDUIT, insertion of, for o	congenital heart disease (Anaes.)
38754	(See para TN.8.67 of <b>Fee:</b> \$2,714.70	explanatory notes to this Category) <b>Benefit:</b> 75% = \$2036.05	
	EXTRACARDIAC	CONDUIT, insertion of, for congenital heart dise	ease (Anaes.) (Assist.)
38757	(See para TN.8.67 of <b>Fee:</b> \$2,168.65	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1626.50	
	EXTRACARDIAC	CONDUIT, replacement of, for congenital heart	disease (Anaes.) (Assist.)
38760	(See para TN.8.67 of <b>Fee:</b> \$2,168.65	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1626.50	
	VENTRICULAR M disease (Anaes.) (A	AYECTOMY, for relief of ventricular obstruction ssist.)	, right or left, for congenital heart
38763	(See para TN.8.67 of <b>Fee:</b> \$2,168.65	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1626.50	
	VENTRICULAR A	AUGMENTATION, right or left, for congenital he	eart disease (Anaes.) (Assist.)
38766	(See para TN.8.67 of <b>Fee:</b> \$2,168.65	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1626.50	
		MISCELLANEOUS PROCEDURES ON TH	IE CHEST
	THORACIC CAVI service to which ite	TY, aspiration of, for diagnostic purposes, not bei m 38803 applies	ing a service associated with a
38800	Fee: \$39.10	<b>Benefit:</b> 75% = \$29.35 85% = \$33.25	
	THORACIC CAVI diagnostic sample	TY, aspiration of, with therapeutic drainage (para	centesis), with or without
38803	Fee: \$78.15	<b>Benefit:</b> 75% = \$58.65 85% = \$66.45	
	INTERCOSTAL D	RAIN, insertion of, not involving resection of rib	(excluding aftercare) (Anaes.)
38806	<b>Fee:</b> \$135.70	<b>Benefit:</b> 75% = \$101.80 85% = \$115.35	
	INTERCOSTAL D aftercare) (Anaes.)	RAIN, insertion of, with pleurodesis and not invo	lving resection of rib (excluding
38809	Fee: \$167.20	<b>Benefit:</b> 75% = \$125.40 85% = \$142.15	
		NEEDLE BIOPSY of lung (Anaes.)	
38812	<b>Fee:</b> \$212.50	<b>Benefit:</b> 75% = \$159.40 85% = \$180.65	
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T8. SUF	RGICAL OPERA	TIONS 7. NEUROSURGICAL		
	Group T8. Sur	gical Operations		
		Subgroup 7. Neurosurgical		
		GENERAL		
	LUMBAR PUN	VCTURE (Anaes.)		
39000	Fee: \$76.50	<b>Benefit:</b> 75% = \$57.40 85% = \$65.05		
	CISTERNAL P	UNCTURE (Anaes.)		
39003	Fee: \$87.00	<b>Benefit:</b> 75% = \$65.25 85% = \$73.95		
	VENTRICULA	R PUNCTURE (not including burr-hole) (Anaes.)		
39006	<b>Fee:</b> \$161.95	<b>Benefit:</b> 75% = \$121.50 85% = \$137.70		
	SUBDURAL H	AEMORRHAGE, tap for, each tap (Anaes.)		
39009	<b>Fee:</b> \$60.30	<b>Benefit:</b> 75% = \$45.25		
	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.)			
39012	Fee: \$241.40	<b>Benefit:</b> 75% = \$181.05		
	or corticosteroic	NDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic d into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary of spinal nerves (Anaes.)		
39013	(See para TN.8.4 <b>Fee:</b> \$110.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$83.20 85% = \$94.30		
		R RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL ONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.)		
39015	(See para TN.8.4 <b>Fee:</b> \$382.00	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$286.50		
39013		NAL FLUID reservoir, insertion of (Anaes.) (Assist.)		
20010				
39018	Fee: \$382.00	<b>Benefit:</b> 75% = \$286.50  PAIN RELIEF		
	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)			
39100	(See para TN.8.4 <b>Fee:</b> \$241.40	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$181.05 85% = \$205.20		
	NEURECTOM	Y, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.)		
39106	Fee: \$1,207.20	<b>Benefit:</b> 75% = \$905.40		
	TRIGEMINAL	GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.)		
39109	Fee: \$450.80	<b>Benefit:</b> 75% = \$338.10 85% = \$383.20		
39112	<del>-  </del>	RVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERATION	ONS	7. NEUROSURGICAL
	Fee: \$1,566.15	<b>Benefit:</b> 75% = \$1174.65	
		S NEUROTOMY of posterior divisions (or ran ociated spinal, epidural or regional nerve block (	
39115	(See para TN.8.4 of <b>Fee:</b> \$76.50	explanatory notes to this Category) <b>Benefit:</b> 75% = \$57.40 85% = \$65.05	
		S NEUROTOMY for facet joint denervation by imaging control (Anaes.) (Assist.)	radio-frequency probe or cryoprobe
39118	(See para TN.8.4 of <b>Fee:</b> \$302.60	explanatory notes to this Category) <b>Benefit:</b> 75% = \$226.95 85% = \$257.25	
	PERCUTANEOU	S CORDOTOMY (Anaes.) (Assist.)	
39121	(See para TN.8.4 of <b>Fee:</b> \$641.85	explanatory notes to this Category) <b>Benefit:</b> 75% = \$481.40 85% = \$557.15	
		R MYELOTOMY, partial or total laminectomy (Anaes.) (Assist.)	y for, or operation for dorsal root entry
39124	Fee: \$1,642.65	<b>Benefit:</b> 75% = \$1232.00	
		ural SPINAL CATHETER insertion or replaced lanted infusion pump, for the management of ch	
39125	Fee: \$302.80	<b>Benefit:</b> 75% = \$227.10	
	intrathecal or epid	P, subcutaneous implantation or replacement of ural catheter, and filling of reservoir with a ther ning the pump, for the management of chronic in	rapeutic agent or agents, with or
39126	<b>Fee:</b> \$367.70	<b>Benefit:</b> 75% = \$275.80	
	SUBCUTANEOU chronic intractable	IS RESERVOIR AND SPINAL CATHETER, i e pain (Anaes.)	nsertion of, for the management of
39127	(See para TN.8.4 of <b>Fee:</b> \$481.25	explanatory notes to this Category) <b>Benefit:</b> 75% = \$360.95	
	insertion of, and c	P, subcutaneous implantation of, AND intratheconnection of pump to catheter, and filling of resthout programming the pump, for the management	servoir with a therapeutic agent or
39128	Fee: \$670.50	<b>Benefit:</b> 75% = \$502.90	
		D, percutaneous placement of, including intraopuronic intractable neuropathic pain or pain from ds (Anaes.)	
39130	(See para TN.8.4 of <b>Fee:</b> \$684.95	explanatory notes to this Category) <b>Benefit:</b> 75% = \$513.75	
	of neurostimulator	pidural or peripheral nerve, management of pat by a medical practitioner, for the management ctory angina pectoris - each day	
39131	Fee: \$129.85	<b>Benefit:</b> 75% = \$97.40 85% = \$110.40	

intrathecal or epidu (See para TN.8.4 of 6 <b>Fee:</b> \$161.95 NEUROSTIMULA	aneously IMPLANTED INFUSION PUMP OR re iral SPINAL CATHETER, for the management of explanatory notes to this Category) <b>Benefit:</b> 75% = \$121.50	1
Fee: \$161.95 NEUROSTIMULA		
	<b>Deficite</b> 7570 = \$121.50	
	ATOR or RECEIVER, subcutaneous placement of, asion wires to epidural or peripheral nerve electrocathic pain or pain from refractory angina pectoris (	des, for the management of chronic
Fee: \$346.05	<b>Benefit:</b> 75% = \$259.55	
neuropathic pain or	pain from refractory angina pectoris, removal of,	
Fee: \$161.95	<b>Benefit:</b> 75% = \$121.50	
neuropathic pain or	pain from refractory angina pectoris, removal of,	
(See para TN.8.4 of 6 <b>Fee:</b> \$161.95	explanatory notes to this Category) <b>Benefit:</b> 75% = \$121.50	
neuropathic pain or or unsatisfactory p	r pain from refractory angina pectoris, surgical repositioning, including intraoperative test stimulation	ositioning to correct displacement
<b>Fee:</b> \$615.05	<b>Benefit:</b> 75% = \$461.30	
management of chi	onic intractable neuropathic pain or pain from refu	
Fee: \$684.95	<b>Benefit:</b> 75% = \$513.75	
intraoperative test	stimulation, for the management of chronic intract	able neuropathic pain or pain from
<b>Fee:</b> \$919.60	<b>Benefit:</b> 75% = \$689.70	
		epidurogram and epidural
Fee: \$297.55	<b>Benefit:</b> 75% = \$223.20 85% = \$252.95	
	PERIPHERAL NERVES	
CUTANEOUS NE (Anaes.) (Assist.)	RVE (including digital nerve), primary repair of,	using microsurgical techniques
Fee: \$359.00	<b>Benefit:</b> 75% = \$269.25	
CUTANEOUS NE (Anaes.) (Assist.)	RVE (including digital nerve), secondary repair of	f, using microsurgical techniques
Fee: \$473.55	<b>Benefit:</b> 75% = \$355.20	
	Fee: \$346.05  NEUROSTIMULA neuropathic pain or of a hospital (Anae Fee: \$161.95  LEAD, epidural or neuropathic pain or of a hospital (Anae (See para TN.8.4 of Fee: \$161.95  LEAD, epidural or neuropathic pain or or unsatisfactory programmer of the pain of or unsatisfactory programmer of the maximum of 4 lead Fee: \$615.05  PERIPHERAL NE management of chi maximum of 4 lead Fee: \$684.95  Epidural lead, surgintraoperative test or refractory angina programmer of the programmer of t	Fee: \$346.05  Benefit: 75% = \$259.55  NEUROSTIMULATOR or RECEIVER, that was inserted for the ma neuropathic pain or pain from refractory angina pectoris, removal of, of a hospital (Anaes.)  Fee: \$161.95  Benefit: 75% = \$121.50  LEAD, epidural or peripheral nerve that was inserted for the manageneuropathic pain or pain from refractory angina pectoris, removal of, of a hospital (Anaes.)  (See para TN.8.4 of explanatory notes to this Category)  Fee: \$161.95  Benefit: 75% = \$121.50  LEAD, epidural or peripheral nerve that was inserted for the manageneuropathic pain or pain from refractory angina pectoris, surgical repor unsatisfactory positioning, including intraoperative test stimulation 39130, 39138 or 39139 applies (Anaes.)  Fee: \$615.05  Benefit: 75% = \$461.30  PERIPHERAL NERVE LEAD, surgical placement of, including intranagement of chronic intractable neuropathic pain or pain from refinaximum of 4 leads (Anaes.) (Assist.)  Fee: \$684.95  Benefit: 75% = \$513.75  Epidural lead, surgical placement of one or more by partial or total la intraoperative test stimulation, for the management of chronic intractive refractory angina pectoris—to a maximum of 4 leads (H) (Anaes.) (A Fee: \$919.60  Benefit: 75% = \$689.70  EPIDURAL CATHETER, insertion of, under imaging control, with otherapeutic injection for lysis of adhesions (Anaes.)  Fee: \$297.55  Benefit: 75% = \$223.20  85% = \$252.95  PERIPHERAL NERVES  CUTANEOUS NERVE (including digital nerve), primary repair of, to (Anaes.) (Assist.)  Fee: \$359.00  Benefit: 75% = \$269.25  CUTANEOUS NERVE (including digital nerve), secondary repair of (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATIO	ONS	7. NEUROSURGICAL	
	NERVE TRUNK,	primary repair of, using m	nicrosurgical techniques (Anaes.) (Assist.)	
39306	<b>Fee:</b> \$687.65	<b>Benefit:</b> 75% = \$515.75		
	NERVE TRUNK,	secondary repair of, using	g microsurgical techniques (Anaes.) (Assist.)	
39309	Fee: \$725.80	<b>Benefit:</b> 75% = \$544.35		
	NERVE TRUNK,	(interfascicular), neurolys	sis of, using microsurgical techniques (Anaes.) (Assist.)	
39312	Fee: \$404.95	<b>Benefit:</b> 75% = \$303.75		
	NERVE TRUNK, techniques (Anaes		t) including harvesting of nerve graft using microsurgical	
39315	Fee: \$1,046.70	<b>Benefit:</b> 75% = \$785.05		
	CUTANEOUS NE (Anaes.) (Assist.)	ERVE (including digital ne	erve), nerve graft to, using microsurgical techniques	
39318	Fee: \$649.45	<b>Benefit:</b> 75% = \$487.10		
Ì	NERVE, transposi	tion of (Anaes.) (Assist.)		
39321	Fee: \$481.25	<b>Benefit:</b> 75% = \$360.95		
ĺ	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.)			
39323	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95	85% = \$239.10	
	NEURECTOMY, operation (Anaes.)		al of tumour from superficial peripheral nerve, by open	
39324	(See para TN.8.4 of <b>Fee:</b> \$281.25	explanatory notes to this Cate Benefit: 75% = \$210.95		
İ			al of tumour from deep peripheral or cranial nerve, by open 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.)	
39327	(See para TN.8.4 of <b>Fee:</b> \$481.35	explanatory notes to this Cate Benefit: 75% = \$361.05		
ĺ		open operation without tr applies (Anaes.) (Assist.)	cansposition, not being a service associated with a service to	
39330	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95		
İ	CARPAL TUNNE	EL RELEASE (division of	transverse carpal ligament), by any method (Anaes.)	
39331	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95	85% = \$239.10	
	BRACHIAL PLEX (Anaes.) (Assist.)	KUS, exploration of, not be	eing a service to which another item in this Group applies	
39333	Fee: \$404.95	<b>Benefit:</b> 75% = \$303.75	85% = \$344.25	
			RANIAL NERVES	
ſ	VESTIBULAR NI	ERVE, section of, via post	terior fossa (Anaes.) (Assist.)	
39500	Fee: \$1,291.25	<b>Benefit:</b> 75% = \$968.45		
39503	FACIO-HYPOGL	OSSAL nerve or FACIO-	ACCESSORY nerve, anastomosis of (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERAT	IONS	7. NEUROSURGICAL
	<b>Fee:</b> \$970.30	<b>Benefit:</b> 75% = \$727.75	
		CRANIO-	CEREBRAL INJURIES
	INTRACRANIA (Assist.)	AL HAEMORRHAGE, burr-l	nole craniotomy for - including burr-holes (Anaes.)
39600	Fee: \$481.25	<b>Benefit:</b> 75% = \$360.95	
	INTRACRANIA of haematoma (A		plastic craniotomy or extensive craniectomy and removal
39603	Fee: \$1,214.85	<b>Benefit:</b> 75% = \$911.15	
	FRACTURED S	KULL, depressed or commir	uted, operation for (Anaes.) (Assist.)
39606	Fee: \$809.85	<b>Benefit:</b> 75% = \$607.40	
	FRACTURED S	KULL, compound, without d	ural penetration, operation for (Anaes.) (Assist.)
39609	<b>Fee:</b> \$970.30	<b>Benefit:</b> 75% = \$727.75	
		KULL, compound, depressed tion for (Anaes.) (Assist.)	l or complicated, with dural penetration and brain
39612	Fee: \$1,138.40	<b>Benefit:</b> 75% = \$853.80	
	FRACTURED S (Anaes.) (Assist.		corrhoea, repair of by cranioplasty or endoscopic approach
39615	Fee: \$1,214.85	<b>Benefit:</b> 75% = \$911.15	
		SKUL	L BASE SURGERY
		OLVING ANTERIOR CRAN kull base, and dural repair (A	TAL FOSSA, removal of, involving craniotomy, radical naes.) (Assist.)
39640	(See para TN.8.70 <b>Fee:</b> \$3,080.15	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$2310.15	egory)
			IIAL FOSSA, removal of, involving frontal craniotomy sal sinus extension (intracranial procedure) (Anaes.)
39642	(See para TN.8.70 <b>Fee:</b> \$3,238.25	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$2428.70	egory)
	with lateral rhino	otomy and radical clearance o	TIAL FOSSA, removal of, involving frontal craniotomy f paranasal sinus and orbital fossa extensions, with (intracranial procedure) (Anaes.) (Assist.)
39646	(See para TN.8.70 <b>Fee:</b> \$3,712.05	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$2784.05	egory)
	of, craniotomy a		L FOSSA AND INFRA-TEMPORAL FOSSA, removal excision, with division and reconstruction of zygomatic .)
39650	(See para TN.8.70 <b>Fee:</b> \$2,685.25	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$2013.95	egory)
39653			removal of, by supra and infratentorial approaches for al procedure), not being a service to which item 39654 or

T8. SUF	RGICAL OPERATIONS 7. NEUROSURG	ICAL
	39656 applies (Anaes.) (Assist.)	
	(See para TN.8.70 of explanatory notes to this Category) <b>Fee:</b> \$4,778.40 <b>Benefit:</b> 75% = \$3583.80	
	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.)	or
39654	(See para TN.8.70 of explanatory notes to this Category) <b>Fee:</b> \$3,475.25 <b>Benefit:</b> 75% = \$2606.45	
	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.)	r
39656	(See para TN.8.70 of explanatory notes to this Category) <b>Fee:</b> \$2,606.35 <b>Benefit:</b> 75% = \$1954.80	
	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral transmaxillary approach (Anaes.) (Assist.)	l or
39658	(See para TN.8.70 of explanatory notes to this Category) <b>Fee:</b> \$3,080.15 <b>Benefit:</b> 75% = \$2310.15	
	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.)	
39660	(See para TN.8.70 of explanatory notes to this Category) <b>Fee:</b> \$3,080.15 <b>Benefit:</b> 75% = \$2310.15	
	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.)	
39662	(See para TN.8.70 of explanatory notes to this Category) <b>Fee:</b> \$3,080.15 <b>Benefit:</b> 75% = \$2310.15	
	INTRA-CRANIAL NEOPLASMS	
	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.)	
39700	<b>Fee:</b> \$565.50 <b>Benefit:</b> 75% = \$424.15	
	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or bot (Anaes.) (Assist.)	th
39703	<b>Fee:</b> \$527.30 <b>Benefit:</b> 75% = \$395.50	
	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.)	
39706	<b>Fee:</b> \$1,130.65 <b>Benefit:</b> 75% = \$848.00	
	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 (Ana (Assist.)	es.)
39709	<b>Fee:</b> \$1,612.15 <b>Benefit:</b> 75% = \$1209.15	
	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item i Sub-group applies (Anaes.) (Assist.)	n this

T8. SUF	RGICAL OPERATI	ONS	7. NEUROSURGICAL
	PITUITARY TU	MOUR, removal of, by transcranial	or transphenoidal approach (Anaes.) (Assist.)
39715	<b>Fee:</b> \$2,017.05	<b>Benefit:</b> 75% = \$1512.80	
0,710		L CYST, craniotomy for (Anaes.) (A	assist.)
39718	Fee: \$886.25	<b>Benefit:</b> 75% = \$664.70	,
39/18	· ·		pening post-operatively for haemorrhage, swelling,
	etc (Anaes.) (Ass		penning post operatively for national ange, swelling,
39721	Fee: \$809.85	<b>Benefit:</b> 75% = \$607.40	
		CEREBROVASC	ULAR DISEASE
	ANEURYSM, cl	ipping or reinforcement of sac (Anac	es.) (Assist.)
39800	Fee: \$2,903.25	<b>Benefit:</b> 75% = \$2177.45	
	INTRACRANIA	L ARTERIOVENOUS MALFORM	ATION, excision of (Anaes.) (Assist.)
39803	Fee: \$2,903.25	<b>Benefit:</b> 75% = \$2177.45	
27002		<u> </u>	anial proximal artery clipping of (Anaes.) (Assist.)
39806	<b>Fee:</b> \$1,306.30	<b>Benefit:</b> 75% = \$979.75	
39000			tula, ligation of cervical vessel or vessels (Anaes.)
	(Assist.)	ETH (EGRETON) of alterio vehicus his	tura, rigation of tel view vesser of vessers (rimes),
39812	Fee: \$641.85	<b>Benefit:</b> 75% = \$481.40	
			- combined cervical and intracranial procedure
	(Anaes.) (Assist.)		
39815	Fee: \$1,856.50	<b>Benefit:</b> 75% = \$1392.40 85% =	\$1771.80
	EXTRACRANIA	AL TO INTRACRANIAL BYPASS	using superficial temporal artery (Anaes.) (Assist.)
39818	Fee: \$1,856.50	<b>Benefit:</b> 75% = \$1392.40	
	EXTRACRANIA	AL TO INTRACRANIAL BYPASS	using saphenous vein graft (Anaes.) (Assist.)
39821	Fee: \$2,204.45	<b>Benefit:</b> 75% = \$1653.35	
		INFEC	TION
	INTRACRANIA	L INFECTION, drainage of, via bur	r-hole - including burr-hole (Anaes.) (Assist.)
39900	Fee: \$527.30	<b>Benefit:</b> 75% = \$395.50	
	INTRACRANIA	L ABSCESS, excision of (Anaes.) (	Assist.)
39903	<b>Fee:</b> \$1,612.15	<b>Benefit:</b> 75% = \$1209.15	
37703			ed bone flap, craniectomy for (Anaes.) (Assist.)
39906	Fee: \$809.85	<b>Benefit:</b> 75% = \$607.40	
39900	Fee. \$809.83	CEREBROSPINAL FLUID C	RCULATION DISORDERS
	VENTRICULO-	CISTERNOSTOMY (Torkildsen's o	
40000	<b>Fee:</b> \$932.10	<b>Benefit:</b> 75% = \$699.10	
70000	+	CISTERNAL SHUNT DIVERSION,	insertion of (Anaes.) (Assist.)
40003			(

T8. SUF	RGICAL OPERATI	ONS 7. NEUROSURGICA		
	Fee: \$932.10	<b>Benefit:</b> 75% = \$699.10		
	LUMBAR SHUN	NT DIVERSION, insertion of (Anaes.) (Assist.)		
40006	Fee: \$733.50	<b>Benefit:</b> 75% = \$550.15		
	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.)			
40009	<b>Fee:</b> \$534.80	<b>Benefit:</b> 75% = \$401.10		
40007		CULOSTOMY (open or endoscopic) with or without endoscopic septum		
	pellucidotomy (Anaes.) (Assist.)			
40012	<b>Fee:</b> \$1,046.70	<b>Benefit:</b> 75% = \$785.05		
	SUBTEMPORA	L DECOMPRESSION (Anaes.) (Assist.)		
40015	<b>Fee:</b> \$648.85	<b>Benefit:</b> 75% = \$486.65		
10015		EBROSPINAL FLUID DRAIN, insertion of (Anaes.)		
40010				
40018	<b>Fee:</b> \$161.95	<b>Benefit:</b> 75% = \$121.50 85% = \$137.70  CONGENITAL DISORDERS		
	MENINGOCELI	E, excision and closure of (Anaes.) (Assist.)		
40100	Fee: \$702.80	Benefit: 75% = \$527.10		
	(Anaes.) (Assist.)	GOCELE, excision and closure of, including skin flaps or Z plasty where performed		
40102				
40103	<b>Fee:</b> \$1,031.50	Benefit: 75% = \$773.65  RI MALFORMATION, decompression of (Anaes.) (Assist.)		
		KI WALFORWATION, decomplession of (Anaes.) (Assist.)		
40106	Fee: \$1,046.70	<b>Benefit:</b> 75% = \$785.05		
	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.)			
40109	Fee: \$1,130.65	<b>Benefit:</b> 75% = \$848.00		
	TETHERED CO	RD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.)		
40112	Fee: \$1,451.60	<b>Benefit:</b> 75% = \$1088.70		
	CRANIOSTENC	SIS, operation for - single suture (Anaes.) (Assist.)		
40115	Fee: \$733.50	<b>Benefit:</b> 75% = \$550.15		
10113		OSIS, operation for - more than 1 suture (Anaes.) (Assist.)		
40110		•		
40118	<b>Fee:</b> \$970.30	Benefit: 75% = \$727.75  SKULL RECONSTRUCTION		
	CRANIOPLASTY, reconstructive (Anaes.) (Assist.)			
40.606				
40600	Fee: \$970.30	<b>Benefit:</b> 75% = \$727.75		
	CORPUS CALL	OSUM, anterior section of, for epilepsy (Anaes.) (Assist.)		
40700	Fee: \$1,772.55	<b>Benefit:</b> 75% = \$1329.45		
40701	Vagus nerve stim	ulation therapy through stimulation of the left vagus nerve, subcutaneous placement of		

T8. SUR	GICAL OPERAT	ONS 7. NEUROSURGICAL
	electrical pulse g	nerator, for:
	(a) management	f refractory generalised epilepsy; or
	(b) treatment of r	fractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
	Fee: \$346.05	<b>Benefit:</b> 75% = \$259.55
		ulation therapy through stimulation of the left vagus nerve, surgical repositioning or cal pulse generator inserted for:
	(a) management	f refractory generalised epilepsy; or
	(b) treatment of r	fractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
40702	Fee: \$161.95	<b>Benefit:</b> 75% = \$121.50
	CORTICECTON	Y, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.)
40703	Fee: \$1,489.75	<b>Benefit:</b> 75% = \$1117.35
		ulation therapy through stimulation of the left vagus nerve, surgical placement of lead, ion of lead to left vagus nerve and intra-operative test stimulation, for:
	(a) management	f refractory generalised epilepsy; or
	(b) treatment of r	fractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
40704	Fee: \$684.95	<b>Benefit:</b> 75% = \$513.75
		ulation therapy through stimulation of the left vagus nerve, surgical repositioning or tached to left vagus nerve for:
	(a) management	f refractory generalised epilepsy; or
	(b) treatment of r	fractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
40705	Fee: \$615.05	<b>Benefit:</b> 75% = \$461.30
	HEMISPHEREC	ΓΟΜΥ for intractable epilepsy (Anaes.) (Assist.)
40706	<b>Fee:</b> \$2,177.40	<b>Benefit:</b> 75% = \$1633.05 85% = \$2092.70
	_	ulation therapy through stimulation of the left vagus nerve, electrical analysis and agus nerve stimulation therapy device using external wand, for:
	(a) management	f refractory generalised epilepsy; or
	(b) treatment of r	fractory focal epilepsy not suitable for resective epilepsy surgery
40707	<b>Fee:</b> \$192.75	<b>Benefit:</b> 75% = \$144.60 85% = \$163.85
		ulation therapy through stimulation of the left vagus nerve, surgical replacement of all pulse generator inserted for:
	(a) management	f refractory generalised epilepsy; or
	(b) treating refrac	tory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)
40708	Fee: \$346.05	<b>Benefit:</b> 75% = \$259.55

T8. SUF	RGICAL OPERATI	ONS	7. NEUROSURGICAI
	BURR-HOLE PI	ACEMENT of intracranial dep	epth or surface electrodes (Anaes.) (Assist.)
40709	<b>Fee:</b> \$527.30	<b>Benefit:</b> 75% = \$395.50	
.0705			NT via craniotomy (Anaes.) (Assist.)
40712	<b>Fee:</b> \$1,061.90	<b>Benefit:</b> 75% = \$796.45	• • • • • • • • • • • • • • • • • • • •
40/12	<b>Fee.</b> \$1,001.90		ACTIC PROCEDURES
	STEREOTACTION		ATION, as an independent procedure (Anaes.) (Assist.)
40800	<b>Fee:</b> \$648.85	<b>Benefit:</b> 75% = \$486.65 85	35% = \$564.15
	FUNCTIONAL S physiological loc	STEREOTACTIC procedure in alisation, and lesion production a service associated with deep be	ncluding computer assisted anatomical localisation, on in the basal ganglia, brain stem or deep white matter brain stimulation for Parkinson's disease, essential tremo
40801	Fee: \$1,773.75	<b>Benefit:</b> 75% = \$1330.35	
		L STEREOTACTIC PROCED 801 applies (Anaes.) (Assist.)	DURE BY ANY METHOD, not being a service to which
40803	Fee: \$1,214.85	<b>Benefit:</b> 75% = \$911.15 85	35% = \$1130.15
	craniectomy and Parkinson's disea	insertion of electrodes for the tr	localisation including twist drill, burr hole craniotomy or treatment of:  e to medical therapy is not sustained and is accompanied
	Essential tremor	or dystonia where the patient's	s symptoms cause severe disability (Anaes.) (Assist.)
40850	<b>Fee:</b> \$2,300.70	<b>Benefit:</b> 75% = \$1725.55	
	anatomical locali		ctional stereotactic procedure including computer assisted ion including twist drill, burr hole craniotomy or treatment of:
		se where the patient's response motor fluctuations; or	e to medical therapy is not sustained and is accompanied
	Essential tremor	or dystonia where the patient's	symptoms cause severe disability. (Anaes.) (Assist.)
40851	Fee: \$4,026.40	<b>Benefit:</b> 75% = \$3019.80	
	DEEP BRAIN ST		bcutaneous placement of neurostimulator receiver or
40852		se where the patient's response motor fluctuations; or	e to medical therapy is not sustained and is accompanied

T8. SUR	RGICAL OPERATIONS 7. NEUF	ROSURGICAL
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes	s.) (Assist.)
	<b>Fee:</b> \$346.05 <b>Benefit:</b> 75% = \$259.55	
	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain electrode for the	e treatment of:
	Parkinson's disease where the patient's response to medical therapy is not sustained and is by unacceptable motor fluctuations; or	accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes	s.)
40854	<b>Fee:</b> \$534.80 <b>Benefit:</b> 75% = \$401.10	
	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neurostimulator regenerator for the treatment of:	eceiver or pulse
	Parkinson's disease where the patient's response to medical therapy is not sustained and is by unacceptable motor fluctuations; or	s accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes	s.)
40856	<b>Fee:</b> \$259.55 <b>Benefit:</b> 75% = \$194.70	
	DEEP BRAIN STIMULATION (unilateral) placement, removal or replacement of extens the treatment of:	sion lead for
	Parkinson's disease where the patient's response to medical therapy is not sustained and is by unacceptable motor fluctuations; or	accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes	s.)
40858	<b>Fee:</b> \$534.80 <b>Benefit:</b> 75% = \$401.10	
	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating anatomical aphysiological techniques, including intra-operative clinical evaluation, for the insertion of neurostimulation wire for the treatment of:	
	Parkinson's disease where the patient's response to medical therapy is not sustained and is by unacceptable motor fluctuations; or	accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes	s.)
40860	<b>Fee:</b> \$2,055.05 <b>Benefit:</b> 75% = \$1541.30	
	DEEP BRAIN STIMULATION (unilateral) electronic analysis and programming of neur pulse generator for the treatment of:	ostimulator
	Parkinson's disease where the patient's response to medical therapy is not sustained and is by unacceptable motor fluctuations; or	s accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes	s.)
40862	<b>Fee:</b> \$192.75 <b>Benefit:</b> 75% = \$144.60 85% = \$163.85	

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGICAL
	MISCELLANEOUS
	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.)
40903	<b>Fee:</b> \$563.40 <b>Benefit:</b> 75% = \$422.55
	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.)
40905	<b>Fee:</b> \$611.35 <b>Benefit:</b> 75% = \$458.55 85% = \$526.65
T8. SUF	RGICAL OPERATIONS 8. EAR, NOSE AND THROAT
	Group T8. Surgical Operations
	Subgroup 8. Ear, Nose And Throat
	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.)
41500	(See para TN.8.72 of explanatory notes to this Category) <b>Fee:</b> \$83.80 <b>Benefit:</b> 75% = \$62.85 85% = \$71.25
	Examination of glottal cycles and vibratory characteristics of the vocal folds by a specialist in the practice of the specialist's specialty of otolaryngology using videostroboscopy, including capturing audio, video, frequency and intensity, for confirmation of diagnosis, or for confirmation of treatment effectiveness where there is failure to progress or respond as expected, for:
	<ul> <li>a. dysphonia where non stroboscopic techniques of the visualising the larynx have failed to identify any frank abnormality of the vocal folds; or</li> <li>b. benign vocal fold lesions; or</li> <li>c. premalignant or malignant laryngeal lesions; or</li> <li>d. vocal fold motion impairment or glottal insufficiency; or</li> <li>e. evaluation of vocal fold function after treatment or phonosurgery</li> </ul>
	other than a service associated with a service to which item 41764 applies or with a services associated with the administration of a general anaesthetic
41501	(See para TN.8.76 of explanatory notes to this Category) <b>Fee:</b> \$188.55 <b>Benefit:</b> 75% = \$141.45  85% = \$160.30
	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.)
41503	<b>Fee:</b> \$242.60 <b>Benefit:</b> 75% = \$181.95 85% = \$206.25
	AURAL POLYP, removal of (Anaes.)
41506	<b>Fee:</b> \$146.30 <b>Benefit:</b> 75% = \$109.75 85% = \$124.40
	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.)
41509	<b>Fee:</b> \$165.55 <b>Benefit:</b> 75% = \$124.20 85% = \$140.75
	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.)
41512	<b>Fee:</b> \$595.25 <b>Benefit:</b> 75% = \$446.45
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service

T8. SUF	RGICAL OPERATIO	NS	8. EAR, NOSE AND THROAT	
	associated with a se	rvice to which item 41530, 41548, 41557	7, 41560 or 41563 applies (Anaes.) (Assist.)	
	(See para TN.8.73 of <b>Fee:</b> \$390.70	explanatory notes to this Category) <b>Benefit:</b> 75% = \$293.05		
	EXTERNAL AUD	ITORY MEATUS, removal of EXOSTO	SES IN (Anaes.) (Assist.)	
41518	<b>Fee:</b> \$943.60	<b>Benefit:</b> 75% = \$707.70		
	Correction of AUD (Anaes.) (Assist.)	ITORY CANAL STENOSIS, including 1	neatoplasty, with or without grafting	
41521	<b>Fee:</b> \$1,004.65	<b>Benefit:</b> 75% = \$753.50		
		ON OF EXTERNAL AUDITORY CANA 57, 41560 and 41563 apply (Anaes.) (Ass	AL, being a service associated with a service iist.)	
41524	(See para TN.8.74 of <b>Fee:</b> \$290.25	explanatory notes to this Category) <b>Benefit:</b> 75% = \$217.70		
	MYRINGOPLAST	Y, transcanal approach (Rosen incision)	(Anaes.) (Assist.)	
41527	<b>Fee:</b> \$597.00	<b>Benefit:</b> 75% = \$447.75		
	MYRINGOPLAST	Y, postaural or endaural approach with o	r without mastoid inspection (Anaes.)	
41530	Fee: \$972.60	<b>Benefit:</b> 75% = \$729.45		
	ATTICOTOMY wi (Assist.)	thout reconstruction of the bony defect, v	with or without myringoplasty (Anaes.)	
41533	<b>Fee:</b> \$1,162.60	<b>Benefit:</b> 75% = \$871.95		
	ATTICOTOMY wi	th reconstruction of the bony defect, with	n or without myringoplasty (Anaes.) (Assist.)	
41536	<b>Fee:</b> \$1,302.20	<b>Benefit:</b> 75% = \$976.65		
	OSSICULAR CHA	IN RECONSTRUCTION (Anaes.) (Assi	st.)	
41539	<b>Fee:</b> \$1,107.35	<b>Benefit:</b> 75% = \$830.55		
	· ·	IN RECONSTRUCTION AND MYRIN	GOPLASTY (Anaes.) (Assist.)	
41542	<b>Fee:</b> \$1,213.35	<b>Benefit:</b> 75% = \$910.05		
11312		IY (CORTICAL) (Anaes.) (Assist.)		
41545	<b>Fee:</b> \$529.60	<b>Benefit:</b> 75% = \$397.20		
41343		OF THE MASTOID CAVITY (Anaes.) (	Assist.)	
41540		, , ,		
41548	Fee: \$702.80	<b>Benefit:</b> 75% = \$527.10 IY, intact wall technique, with myringopl	asty (Anaes ) (Assist )	
41.551			(Times), (Tissisti)	
41551	<b>Fee:</b> \$1,618.55	<b>Benefit:</b> 75% = \$1213.95 IY, intact wall technique, with myringopl	acty and occioular chain reconstruction	
	(Anaes.) (Assist.)	11, maet wan teemiique, with mymigopi	and ossicular chain reconstruction	
41554	<b>Fee:</b> \$1,907.00	<b>Benefit:</b> 75% = \$1430.25		
	· ·	IY (RADICAL OR MODIFIED RADICA	AL) (Anaes.) (Assist.)	
41557	<b>Fee:</b> \$1,107.35	<b>Benefit:</b> 75% = \$830.55		
11331	μ. ψ1,107.33	<b>ΣΟΙΙΟΙΙΟ</b> 1570 — ΨΟΙΟ.ΙΙ		

T8. SUF	RGICAL OPERATION	ONS	8. EAR, NOSE AND THROAT
	MASTOIDECTO	MY (RADICAL OR MODIF	IED RADICAL) AND MYRINGOPLASTY (Anaes.)
41560	<b>Fee:</b> \$1,213.35	<b>Benefit:</b> 75% = \$910.05	
		MY (RADICAL OR MODIF AIN RECONSTRUCTION (	IED RADICAL), MYRINGOPLASTY AND Anaes.) (Assist.)
41563	Fee: \$1,502.05	<b>Benefit:</b> 75% = \$1126.55	
	CAVITY, BLIND		IED RADICAL), OBLITERATION OF THE MASTOID RNAL AUDITORY CANAL AND OBLITERATION
41564	Fee: \$1,942.40	<b>Benefit:</b> 75% = \$1456.80	
	REVISION OF M (Anaes.) (Assist.)	ASTOIDECTOMY (radical,	modified radical or intact wall), including myringoplasty
41566	<b>Fee:</b> \$1,107.35	<b>Benefit:</b> 75% = \$830.55	
	DECOMPRESSION	ON OF FACIAL NERVE in i	ts mastoid portion (Anaes.) (Assist.)
41569	Fee: \$1,213.35	<b>Benefit:</b> 75% = \$910.05	
	LABYRINTHOT	OMY OR DESTRUCTION (	OF LABYRINTH (Anaes.) (Assist.)
41572	<b>Fee:</b> \$1,049.75	<b>Benefit:</b> 75% = \$787.35	
	transmastoid, tran		removal of by 2 surgeons operating conjointly, by approach transmastoid, translabyrinthine or retromastoid t.)
41575	Fee: \$2,474.65	<b>Benefit:</b> 75% = \$1856.00	
	retromastoid appro		t, removal of, by transmastoid, translabyrinthine or (including aftercare) not being a service to which item
41576	Fee: \$3,712.05	<b>Benefit:</b> 75% = \$2784.05	
			removal of, by transmastoid, translabyrinthine or - conjoint surgery, principal surgeon (Anaes.) (Assist.)
41578	Fee: \$2,474.65	<b>Benefit:</b> 75% = \$1856.00	
			removal of, by transmastoid, translabyrinthine or - conjoint surgery, co-surgeon (Assist.)
41579	Fee: \$1,856.00	<b>Benefit:</b> 75% = \$1392.00	
	TUMOUR INVO		L FOSSA, removal of, involving craniotomy and radical
41581	<b>Fee:</b> \$2,846.35	<b>Benefit:</b> 75% = \$2134.80	
			for removal of tumour involving mastoidectomy with or
	without decompre	ssion of facial nerve (Anaes.)	(Assist.)
41584	Fee: \$1,953.40	<b>Benefit:</b> 75% = \$1465.05	
	TOTAL TEMPOR	RAL BONE RESECTION for	removal of tumour (Anaes.) (Assist.)
41587	Fee: \$2,660.50	<b>Benefit:</b> 75% = \$1995.40	

	RGICAL OPERATION	ONS	8. EAR, NOSE AND THROAT
	ENDOLYMPHA' (Anaes.) (Assist.)		D DECOMPRESSION with or without drainage of
41590	Fee: \$1,213.35	<b>Benefit:</b> 75% = \$910.05	
	TRANSLABYRI	NTHINE VESTIBULAR NE	ERVE SECTION (Anaes.) (Assist.)
41593	Fee: \$1,581.40	<b>Benefit:</b> 75% = \$1186.05	
	RETROLABYRI BOTH (Anaes.) (A		ERVE SECTION or COCHLEAR NERVE SECTION, or
41596	<b>Fee:</b> \$1,767.35	<b>Benefit:</b> 75% = \$1325.55	
	INTERNAL AUD decompression (A		tion by middle cranial fossa approach with cranial nerve
41599	<b>Fee:</b> \$1,767.35	<b>Benefit:</b> 75% = \$1325.55	
		ATION PROCEDURE - implearing system device, in pat	plantation of titanium fixture for use with implantable ients:
	- With a permar	nent or long term hearing loss	s; and
	- Unable to utili	se conventional air or bone of	conduction hearing aid for medical or audiological reasons;
		nduction thresholds that accong device being inserted.	rd to recognised criteria for the implantable bone
	Not being a service	ce associated with a service to	o which items 41554, 45794 or 45797 (Anaes.)
41603	<b>Fee:</b> \$511.90	<b>Benefit:</b> 75% = \$383.95	85% = \$435.15
	OSSEO-INTEGR	ATION PROCEDURE - fix:	ation of transcutaneous abutment implantation of titanium
		h implantable bone conducti	on hearing system device, in patients:
	fixture for use wit	th implantable bone conduction ment or long term hearing loss	on hearing system device, in patients:
	fixture for use wit - With a permar	nent or long term hearing loss	on hearing system device, in patients:
	fixture for use wit  - With a perman  - Unable to utili and  - With bone cor	nent or long term hearing loss	on hearing system device, in patients: s; and
	fixture for use wit  - With a perman  - Unable to utiliand  - With bone conconduction hearing	nent or long term hearing loss ise conventional air or bone of aduction thresholds that according device being inserted.	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons;
41604	fixture for use wit  - With a perman  - Unable to utiliand  - With bone conconduction hearing	nent or long term hearing loss ise conventional air or bone of aduction thresholds that according device being inserted.	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons; rd to recognised criteria for the implantable bone o which items 41554, 45794 or 45797 (Anaes.)
41604	fixture for use wit  - With a perman  - Unable to utili and  - With bone conconduction hearin  Not being a service  Fee: \$189.50	nent or long term hearing loss ise conventional air or bone of induction thresholds that according device being inserted.	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons; rd to recognised criteria for the implantable bone o which items 41554, 45794 or 45797 (Anaes.)
41604	fixture for use wit  - With a perman  - Unable to utili and  - With bone conconduction hearin  Not being a service  Fee: \$189.50	nent or long term hearing loss is conventional air or bone of aduction thresholds that according device being inserted.  The associated with a service to the associated with a service to the according to the associated with a service to the according to the acc	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons; rd to recognised criteria for the implantable bone o which items 41554, 45794 or 45797 (Anaes.)
	fixture for use wit  - With a perman  - Unable to utiliand  - With bone corconduction hearin  Not being a service  Fee: \$189.50  STAPEDECTOM  Fee: \$1,107.35	nent or long term hearing loss is conventional air or bone of aduction thresholds that according device being inserted.  Benefit: 75% = \$142.15  IY (Anaes.) (Assist.)	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons; rd to recognised criteria for the implantable bone o which items 41554, 45794 or 45797 (Anaes.)
41608	fixture for use wit  - With a perman  - Unable to utiliand  - With bone corconduction hearin  Not being a service  Fee: \$189.50  STAPEDECTOM  Fee: \$1,107.35  STAPES MOBIL	nent or long term hearing loss is conventional air or bone of aduction thresholds that according device being inserted.  Benefit: 75% = \$142.15  IY (Anaes.) (Assist.)  Benefit: 75% = \$830.55  ISATION (Anaes.) (Assist.)	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons; rd to recognised criteria for the implantable bone o which items 41554, 45794 or 45797 (Anaes.)
	fixture for use wit  - With a perman  - Unable to utiliand  - With bone corconduction hearin  Not being a service  Fee: \$189.50  STAPEDECTOM  Fee: \$1,107.35  STAPES MOBIL  Fee: \$712.50	nent or long term hearing loss is conventional air or bone of aduction thresholds that according device being inserted.  The associated with a service to the associa	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons; rd to recognised criteria for the implantable bone o which items 41554, 45794 or 45797 (Anaes.)
41608	fixture for use wit  - With a perman  - Unable to utiliand  - With bone corconduction hearin  Not being a service  Fee: \$189.50  STAPEDECTOM  Fee: \$1,107.35  STAPES MOBIL  Fee: \$712.50	nent or long term hearing loss is conventional air or bone of aduction thresholds that according device being inserted.  The associated with a service to the associa	on hearing system device, in patients: s; and conduction hearing aid for medical or audiological reasons; rd to recognised criteria for the implantable bone o which items 41554, 45794 or 45797 (Anaes.) 85% = \$161.10

T8. SUF	GICAL OPERATIONS 8. EAR, NOSE AND THRO	AT
	to which any other item in this Group applies (Anaes.) (Assist.)	
	<b>Fee:</b> \$1,107.35 <b>Benefit:</b> 75% = \$830.55 85% = \$1022.65	
	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.)	
41617	Fee: \$1,925.50 Benefit: 75% = \$1444.15	
	Middle ear implant, partially implantable, insertion of, via mastoidectomy, for patients with:	
	(a) stable sensorineural hearing loss; and	
	(b) outer ear pathology that prevents the use of a conventional hearing aid; and	
	(c) a PTA4 of less than 80 dBHL; and	
	(d) bilateral, symmetrical hearing loss with PTA thresholds in both ears within 20 dBHL (0.5-4kHz) o each other; and	f
	(e) speech perception discrimination of at least 65% correct for word lists with appropriately amplified sound; and	i
	(f) a normal middle ear; and	
	(g) normal tympanometry; and	
	(h) on audiometry, an air-bone gap of less than 10 dBHL (0.5-4kHz) across all frequencies; and	
	(i) no other inner ear disorders	
	(Anaes.) (Assist.)	
41618	<b>Fee:</b> \$1,907.00 <b>Benefit:</b> 75% = \$1430.25	
	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.)	
41620	<b>Fee:</b> \$837.75 <b>Benefit:</b> 75% = \$628.35	
	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.)	
41623	<b>Fee:</b> \$1,213.35 <b>Benefit:</b> 75% = \$910.05	
41023	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.)	
41626	(See para TN.8.4 of explanatory notes to this Category) <b>Fee:</b> \$146.30 <b>Benefit:</b> 75% = \$109.75 85% = \$124.40	
	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.)	
41629	<b>Fee:</b> \$529.60 <b>Benefit:</b> 75% = \$397.20	
71027	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.)	
41.622		
41632	Fee: \$242.60 Benefit: 75% = \$181.95 85% = \$206.25	***
	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more with or without myringoplasty (Anaes.) (Assist.)	re,
41635	<b>Fee:</b> \$1,162.60 <b>Benefit:</b> 75% = \$871.95 85% = \$1077.90	
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more	re,

Fee: \$1,451.20 PERFORATION OF Fee: \$48.20 EXCISION OF RI myringoplasty (Ar Fee: \$145.10 EAR TOILET requor without general Fee: \$111.65 TYMPANIC MEM service associated	Benefit: 75% = \$1088.40  OF TYMPANUM, cauterisation or diathermy of (Anaes.)  Benefit: 75% = \$36.15
PERFORATION OF Fee: \$48.20 EXCISION OF RI myringoplasty (Ar Fee: \$145.10 EAR TOILET requor without general Fee: \$111.65 TYMPANIC MEM service associated	Benefit: 75% = \$36.15  85% = \$41.00  M OF EARDRUM PERFORATION, not being a service associated with naes.)  Benefit: 75% = \$108.85  85% = \$123.35  uiring use of operating microscope and microinspection of tympanic membrane with anaesthesia (Anaes.)  Benefit: 75% = \$83.75  85% = \$94.95  MBRANE, microinspection of 1 or both ears under general anaesthesia, not being a
PERFORATION OF Fee: \$48.20 EXCISION OF RI myringoplasty (Ar Fee: \$145.10 EAR TOILET requor without general Fee: \$111.65 TYMPANIC MEM service associated	Benefit: 75% = \$36.15  85% = \$41.00  M OF EARDRUM PERFORATION, not being a service associated with naes.)  Benefit: 75% = \$108.85  85% = \$123.35  uiring use of operating microscope and microinspection of tympanic membrane with anaesthesia (Anaes.)  Benefit: 75% = \$83.75  85% = \$94.95  MBRANE, microinspection of 1 or both ears under general anaesthesia, not being a
Fee: \$48.20 EXCISION OF RI myringoplasty (Ar Fee: \$145.10 EAR TOILET requor without general Fee: \$111.65 TYMPANIC MEM service associated	Benefit: 75% = \$36.15 85% = \$41.00  M OF EARDRUM PERFORATION, not being a service associated with maes.)  Benefit: 75% = \$108.85 85% = \$123.35  The properties of operating microscope and microinspection of tympanic membrane with anaesthesia (Anaes.)  Benefit: 75% = \$83.75 85% = \$94.95  MBRANE, microinspection of 1 or both ears under general anaesthesia, not being a
EXCISION OF RI myringoplasty (Ar Fee: \$145.10  EAR TOILET requor without general Fee: \$111.65  TYMPANIC MEM service associated	M OF EARDRUM PERFORATION, not being a service associated with maes.)  Benefit: 75% = \$108.85
myringoplasty (Ar Fee: \$145.10 EAR TOILET required or without general Fee: \$111.65 TYMPANIC MEM service associated	Benefit: 75% = \$108.85  85% = \$123.35  uiring use of operating microscope and microinspection of tympanic membrane with anaesthesia (Anaes.)  Benefit: 75% = \$83.75  85% = \$94.95  MBRANE, microinspection of 1 or both ears under general anaesthesia, not being a
EAR TOILET requor without general  Fee: \$111.65  TYMPANIC MEN service associated	uiring use of operating microscope and microinspection of tympanic membrane with anaesthesia (Anaes.)  Benefit: 75% = \$83.75  85% = \$94.95  MBRANE, microinspection of 1 or both ears under general anaesthesia, not being a
or without general Fee: \$111.65 TYMPANIC MEN service associated	anaesthesia (Anaes.)  Benefit: 75% = \$83.75 85% = \$94.95  MBRANE, microinspection of 1 or both ears under general anaesthesia, not being a
TYMPANIC MEN service associated	MBRANE, microinspection of 1 or both ears under general anaesthesia, not being a
service associated	
<b>Fee:</b> \$111.65	<b>Benefit:</b> 75% = \$83.75 85% = \$94.95
POSTNASAL SPA	OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND ACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a nother item in this Group applies (Anaes.)
<b>Fee:</b> \$73.10	<b>Benefit:</b> 75% = \$54.85 85% = \$62.15
	RRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without with or without anterior pack (excluding aftercare) (Anaes.)
(See para TN.8.4 of <b>Fee:</b> \$124.80	explanatory notes to this Category) <b>Benefit:</b> 75% = \$93.60 85% = \$106.10
NOSE, removal of	FOREIGN BODY IN, other than by simple probing (Anaes.)
Fee: \$78.80	<b>Benefit:</b> 75% = \$59.10 85% = \$67.00
NASAL POLYP (	OR POLYPI (SIMPLE), removal of
(See para TN.8.75 or <b>Fee:</b> \$83.80	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$62.85 85% = \$71.25
NASAL POLYP (	OR POLYPI, removal of (Anaes.)
(See para TN.8.75 or <b>Fee:</b> \$223.45	f explanatory notes to this Category) <b>Benefit:</b> 75% = \$167.60
NASAL SEPTUM (Anaes.)	I, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation
(See para TN.8.104 ( <b>Fee:</b> \$491.00	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$368.25
NASAL SEPTUM	(, reconstruction of (Anaes.) (Assist.)
Fee: \$612.50	<b>Benefit:</b> 75% = \$459.40
general anaesthesi	er than by chemical means) or cauterisation by chemical means when performed under a or diathermy of septum or turbinates—one or more of these procedures (including in the same occasion) other than a service associated with another operation on the
	POSTNASAL SPA service to which an Fee: \$73.10  NASAL HAEMOD cauterisation and volumerisation and volumerisat

T8. SUF	RGICAL OPERATI	IONS 8. EAR, NOSE AND THROAT
	nose (Anaes.)	
	Fee: \$102.10	<b>Benefit:</b> 75% = \$76.60 85% = \$86.80
	NASAL HAEMO packing or both (	ORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity Anaes.)
41677	<b>Fee:</b> \$91.45	<b>Benefit:</b> 75% = \$68.60 85% = \$77.75
		ASAL ADHESIONS, with or without stenting not being a service associated with any in the nose and not performed during the postoperative period of a nasal operation
41683	Fee: \$119.10	<b>Benefit:</b> 75% = \$89.35 85% = \$101.25
		OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated which another item in this Group applies (Anaes.)
41686	Fee: \$73.10	<b>Benefit:</b> 75% = \$54.85 85% = \$62.15
	TURBINECTON	MY or turbinectomies, partial or total, unilateral (Anaes.)
41689	Fee: \$138.70	<b>Benefit:</b> 75% = \$104.05
	TURBINATES,	submucous resection of, unilateral (Anaes.)
41692	Fee: \$180.90	<b>Benefit:</b> 75% = \$135.70
	MAXILLARY A	NTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.)
41698	Fee: \$33.05	<b>Benefit:</b> 75% = \$24.80 85% = \$28.10
		NTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission eing a service associated with a service to which another item in this Group applies
41701	Fee: \$93.35	<b>Benefit:</b> 75% = \$70.05
		NTRUM, LAVAGE OF each attendance at which the procedure is performed, sociated consultation (Anaes.)
41704	Fee: \$36.90	<b>Benefit:</b> 75% = \$27.70 85% = \$31.40
	MAXILLARY A	RTERY, transantral ligation of (Anaes.) (Assist.)
41707	Fee: \$455.75	<b>Benefit:</b> 75% = \$341.85
	ANTROSTOMY	(RADICAL) (Anaes.) (Assist.)
41710	Fee: \$529.60	<b>Benefit:</b> 75% = \$397.20
	ANTROSTOMY (Anaes.) (Assist.)	(RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy
41713	Fee: \$616.20	<b>Benefit:</b> 75% = \$462.15
	ANTRUM, intra	nasal operation on, or removal of foreign body from (Anaes.) (Assist.)
41716	Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35
	ANTRUM, drain	age of, through tooth socket (Anaes.)
41719	<b>Fee:</b> \$119.45	<b>Benefit:</b> 75% = \$89.60 85% = \$101.55

T8. SUF	RGICAL OPERAT	ONS 8. EAR, NOSE AND THROAT
	OROANTRAL F	FISTULA, plastic closure of (Anaes.) (Assist.)
41722	Fee: \$597.00	<b>Benefit:</b> 75% = \$447.75 85% = \$512.30
	ETHMOIDAL A	RTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.)
41725	Fee: \$455.75	<b>Benefit:</b> 75% = \$341.85
	LATERAL RHI	NOTOMY with removal of tumour (Anaes.) (Assist.)
41728	<b>Fee:</b> \$911.65	<b>Benefit:</b> 75% = \$683.75
	DERMOID OF N	NOSE, excision of, with intranasal extension (Anaes.) (Assist.)
41729	Fee: \$577.75	<b>Benefit:</b> 75% = \$433.35
	FRONTONASA (Assist.)	L ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.)
41731	Fee: \$789.55	<b>Benefit:</b> 75% = \$592.20
	RADICAL FRO	NTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.)
41734	Fee: \$1,030.25	<b>Benefit:</b> 75% = \$772.70
	FRONTAL SINU (Anaes.) (Assist.)	US, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on
41737	Fee: \$491.00	<b>Benefit:</b> 75% = \$368.25
	FRONTAL SINU	JS, catheterisation of (Anaes.)
41740	Fee: \$59.75	<b>Benefit:</b> 75% = \$44.85
	FRONTAL SINU	JS, trephine of (Anaes.) (Assist.)
41743	Fee: \$342.85	<b>Benefit:</b> 75% = \$257.15
	FRONTAL SINU	JS, radical obliteration of (Anaes.) (Assist.)
41746	Fee: \$789.55	<b>Benefit:</b> 75% = \$592.20 85% = \$704.85
	ETHMOIDAL S	INUSES, external operation on (Anaes.) (Assist.)
41749	Fee: \$616.20	<b>Benefit:</b> 75% = \$462.15
	SPHENOIDAL S	SINUS, intranasal operation on (Anaes.) (Assist.)
41752	Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35
	EUSTACHIAN '	ΓUBE, catheterisation of (Anaes.)
41755	Fee: \$47.25	<b>Benefit:</b> 75% = \$35.45 85% = \$40.20
		PY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and r more of these procedures, unilateral or bilateral examination (Anaes.)
41764	Fee: \$124.80	<b>Benefit:</b> 75% = \$93.60 85% = \$106.10
	NASOPHARYN	GEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.)
41767	<b>Fee:</b> \$748.80	<b>Benefit:</b> 75% = \$561.60 85% = \$664.10
	·	POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.)
41770		

. 0. 001	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	Fee: \$712.50	<b>Benefit:</b> 75% = \$534.40
	PHARYNGEAL	POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.)
41773	Fee: \$597.00	<b>Benefit:</b> 75% = \$447.75
	CRICOPHARY	NGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)
41776	Fee: \$595.25	<b>Benefit:</b> 75% = \$446.45
	PHARYNGOTO	OMY (lateral), with or without total excision of tongue (Anaes.) (Assist.)
41779	<b>Fee:</b> \$712.50	<b>Benefit:</b> 75% = \$534.40
		RYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)
41782	<b>Fee:</b> \$967.35	<b>Benefit:</b> 75% = \$725.55 85% = \$882.65
,,,,	·	RYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.)
41785	Fee: \$1,200.05	<b>Benefit:</b> 75% = \$900.05
	UVULOPALAT (Assist.)	OPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.)
41786	Fee: \$748.80	<b>Benefit:</b> 75% = \$561.60
		Y AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, consillectomy, 1 or more stages, including any revision procedures within 12 months )
41787	Fee: \$577.75	<b>Benefit:</b> 75% = \$433.35 85% = \$493.05
	examination of the	s and adenoids, removal of, in a person aged less than 12 years (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies
	(Anaes.)	
41789		
	<b>Fee:</b> \$300.45	<b>Benefit:</b> 75% = \$225.35
	Tonsils or tonsils examination of the	<b>Benefit:</b> 75% = \$225.35 s and adenoids, removal of, in a person 12 years of age or over (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)
41793	Tonsils or tonsils examination of the	s and adenoids, removal of, in a person 12 years of age or over (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a
	Tonsils or tonsils examination of the service to which  Fee: \$377.45  TONSILS OR To	s and adenoids, removal of, in a person 12 years of age or over (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)
	Tonsils or tonsils examination of the service to which  Fee: \$377.45  TONSILS OR To	s and adenoids, removal of, in a person 12 years of age or over (including any he postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)  Benefit: 75% = \$283.10  ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general
41793	Tonsils or tonsils examination of the service to which  Fee: \$377.45  TONSILS OR Tonanaesthesia, following the service of the	s and adenoids, removal of, in a person 12 years of age or over (including any the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)  Benefit: 75% = \$283.10  ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general owing removal of (Anaes.)
41793 41797	Tonsils or tonsils examination of the service to which  Fee: \$377.45  TONSILS OR Tonsils of the service to which  Fee: \$146.30  Adenoids, removinfiltration of local	s and adenoids, removal of, in a person 12 years of age or over (including any the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)  Benefit: 75% = \$283.10  ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general owing removal of (Anaes.)  Benefit: 75% = \$109.75  val of (including any examination of the postnasal space and nasopharynx and the cal anaesthetic), not being a service to which item 41764 applies (Anaes.)
41793	Tonsils or tonsils examination of the service to which  Fee: \$377.45  TONSILS OR Tonsils of the service to which  Fee: \$146.30  Adenoids, removinfiltration of local fee: \$165.55	s and adenoids, removal of, in a person 12 years of age or over (including any the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a item 41764 applies (Anaes.)  Benefit: 75% = \$283.10  ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general owing removal of (Anaes.)  Benefit: 75% = \$109.75  val of (including any examination of the postnasal space and nasopharynx and the

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THRO	TAC
	PERITONSILL	AR ABSCESS (quinsy), incision of (Anaes.)	
41807	Fee: \$71.20	<b>Benefit:</b> 75% = \$53.40 85% = \$60.55	
	UVULOTOMY	or UVULECTOMY (Anaes.)	
41810	Fee: \$36.15	<b>Benefit:</b> 75% = \$27.15 85% = \$30.75	
	VALLECULAR	OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)	
41813	Fee: \$362.05	<b>Benefit:</b> 75% = \$271.55	
	OESOPHAGOS	COPY (with rigid oesophagoscope) (Anaes.)	
41816	Fee: \$188.55	<b>Benefit:</b> 75% = \$141.45 85% = \$160.30	
	OESOPHAGOS	COPY (with rigid oesophagoscope), with biopsy (Anaes.)	
41822	Fee: \$242.60	<b>Benefit:</b> 75% = \$181.95	
	OESOPHAGOS	COPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.)	
41825	Fee: \$362.05	<b>Benefit:</b> 75% = \$271.55	
	OESOPHAGEA	L STRICTURE, dilatation of, without oesophagoscopy (Anaes.)	
41828	Fee: \$53.05	<b>Benefit:</b> 75% = \$39.80 85% = \$45.10	
	Oesophagus, end	loscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.)	
41831	<b>Fee:</b> \$362.70	<b>Benefit:</b> 75% = \$272.05 85% = \$308.30	
	OESOPHAGUS	, balloon dilatation of, using interventional imaging techniques (Anaes.)	
41832	Fee: \$232.15	<b>Benefit:</b> 75% = \$174.15 85% = \$197.35	
	LARYNGECTO	MY (TOTAL) (Anaes.) (Assist.)	
41834	Fee: \$1,309.80	<b>Benefit:</b> 75% = \$982.35	
		MILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)	
41837	Fee: \$1,255.85	<b>Benefit:</b> 75% = \$941.90	
		IC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.)	-
41840	<b>Fee:</b> \$1,544.10	<b>Benefit:</b> 75% = \$1158.10	
	LARYNGOPHA	RYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUI	TY
	after laryngopha	ryngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)	
41843	Fee: \$1,357.85	<b>Benefit:</b> 75% = \$1018.40	
	MICROLARYN	GOSCOPY (Anaes.) (Assist.)	
41855	Fee: \$292.80	<b>Benefit:</b> 75% = \$219.60	
	MICROLARYN	GOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.)	
41050		of explanatory notes to this Category)	
41858	Fee: \$502.05	<b>Benefit:</b> 75% = \$376.55  GOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.)	
41061	(Assist.)	Goodest 1 with removal of beingh lesions of the farying by faser surgery (Allacs.)	
41861			

T8. SUF	RGICAL OPERAT	ONS 8. EAR, NOSE AND THROAT
	Fee: \$613.95	<b>Benefit:</b> 75% = \$460.50
	MICROLARYN	GOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)
41864	Fee: \$414.00	<b>Benefit:</b> 75% = \$310.50
	MICROLARYN	GOSCOPY with arytenoidectomy (Anaes.) (Assist.)
41867	Fee: \$623.20	<b>Benefit:</b> 75% = \$467.40
	LARYNGEAL V	VEB, division of, using microlarygoscopic techniques (Anaes.)
41868	Fee: \$394.90	<b>Benefit:</b> 75% = \$296.20
	· ·	VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.)
41870	Fee: \$462.15	<b>Benefit:</b> 75% = \$346.65
41070		CTURED, operation for (Anaes.) (Assist.)
41873	<b>Fee:</b> \$597.00	<b>Benefit:</b> 75% = \$447.75 85% = \$512.30
41073		nal operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.)
	(Assist.)	operation on, one 22 area (contract man or man or or or or or or or or or or or or or
41876	Fee: \$597.00	<b>Benefit:</b> 75% = \$447.75 85% = \$512.30
	LARYNGOPLA	STY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.)
41879	Fee: \$967.35	<b>Benefit:</b> 75% = \$725.55
	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.)	
41880	Fee: \$258.20	<b>Benefit:</b> 75% = \$193.65
		MY by open exposure of the trachea, including separation of the strap muscles or yroid isthmus, where performed (Anaes.) (Assist.)
41881	Fee: \$408.20	<b>Benefit:</b> 75% = \$306.15
	CRICOTHYRO	STOMY by direct stab or Seldinger technique, using mini tracheostomy device (Anaes.)
41884	Fee: \$92.50	<b>Benefit:</b> 75% = \$69.40
		PHAGEAL FISTULA, formation of, as a secondary procedure following cluding associated endoscopic procedures (Anaes.) (Assist.)
41885	Fee: \$292.50	<b>Benefit:</b> 75% = \$219.40 85% = \$248.65
	TRACHEA, rem	oval of foreign body in (Anaes.)
41886	Fee: \$180.90	<b>Benefit:</b> 75% = \$135.70 85% = \$153.80
	BRONCHOSCOPY, as an independent procedure (Anaes.)	
41889	Fee: \$180.90	<b>Benefit:</b> 75% = \$135.70 85% = \$153.80
		PY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures
41892	Fee: \$238.80	<b>Benefit:</b> 75% = \$179.10 85% = \$203.00
		moval of foreign body in (Anaes.) (Assist.)
41895		

T8. SUI	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	Fee: \$373.65	<b>Benefit:</b> 75% = \$280.25
		RONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without achoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.)
41898	Fee: \$261.05	<b>Benefit:</b> 75% = \$195.80 85% = \$221.90
		LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction sociated endoscopic procedures (Anaes.) (Assist.)
41901	Fee: \$613.95	<b>Benefit:</b> 75% = \$460.50
	BRONCHOSCO	PY with dilatation of tracheal stricture (Anaes.)
41904	Fee: \$250.45	<b>Benefit:</b> 75% = \$187.85 85% = \$212.90
	TRACHEA OR	BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.)
41905	<b>Fee:</b> \$460.60	<b>Benefit:</b> 75% = \$345.45
	NASAL SEPTU	M BUTTON, insertion of (Anaes.)
41907	Fee: \$124.80	<b>Benefit:</b> 75% = \$93.60 85% = \$106.10
	DUCT OF MAJ	OR SALIVARY GLAND, transposition of (Anaes.) (Assist.)
41910	Fee: \$396.50	<b>Benefit:</b> 75% = \$297.40
T8. SU	RGICAL OPERAT	IONS 9. OPHTHALMOLOGY
	Group T8. Surg	cal Operations
		Subgroup 9. Ophthalmology
		OGICAL EXAMINATION under general anaesthesia, not being a service associated which another item in this Group applies (Anaes.)
42503	Fee: \$104.15	<b>Benefit:</b> 75% = \$78.15
		al from the eye of a trans-trabecular drainage device or devices, with or without owing device related medical complications necessitating complete removal. (Anaes.)
42505	Fee: \$305.55 Extended Medi	<b>Benefit:</b> 75% = \$229.20 85% = \$259.75 care Safety Net Cap: \$45.85
	EYE, ENUCLE	ATION OF, with or without sphere implant (Anaes.) (Assist.)
42506	Fee: \$488.95	<b>Benefit:</b> 75% = \$366.75 85% = \$415.65
	EYE, ENUCLE	ATION OF, with insertion of integrated implant (Anaes.) (Assist.)
42509	<b>Fee:</b> \$618.80	<b>Benefit:</b> 75% = \$464.10
	EVE anualantia	
	(Assist.)	n of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.)
42510	· ·	n of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) <b>Benefit:</b> 75% = \$535.00
42510	(Assist.) <b>Fee:</b> \$713.30	
42510 42512	(Assist.) <b>Fee:</b> \$713.30	<b>Benefit:</b> 75% = \$535.00

			HTHALMOLOGY
	(Anaes.) (Assist.)	)	
	Fee: \$618.80	<b>Benefit:</b> 75% = \$464.10	
	procedure, or RE	IIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLEMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A PEG by drilling into an existing orbital implant (Anaes.) (Assist.)	
42518	<b>Fee:</b> \$359.00	<b>Benefit:</b> 75% = \$269.25	
		IIC SOCKET, treatment of, by insertion of a wired-in conformer, inte s a secondary procedure (Anaes.) (Assist.)	grated implant or
42521	Fee: \$1,222.45	<b>Benefit:</b> 75% = \$916.85	
	ORBIT, SKIN G	RAFT TO, as a delayed procedure (Anaes.)	
42524	Fee: \$207.85	<b>Benefit:</b> 75% = \$155.90 85% = \$176.70	
		SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBR OULD (Anaes.) (Assist.)	ANE GRAFTING
42527	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	
	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anae		Anaes.) (Assist.)
42530	<b>Fee:</b> \$641.85	<b>Benefit:</b> 75% = \$481.40	
	ORBIT, EXPLO	RATION OF, with drainage or biopsy not requiring removal of bone	(Anaes.) (Assist.)
42533	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	
	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.)		ralis muscle
42536	<b>Fee:</b> \$847.95	<b>Benefit:</b> 75% = \$636.00	
	ORBIT, EXPLO	RATION OF, with removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal of tumour or foreign body, requiring removal or foreign body, requiring removal or foreign body, requiring removal or foreign body, requiring removal or foreign body, requiring removal or foreign body, requiring the foreign body and the foreign body and the foreign body are the foreign body and the foreign body are the foreign body and the foreign body are the foreign body and the foreign body are the foreign body and the foreign body are the foreign body and the foreign body are the for	oval of bone
42539	Fee: \$1,207.20	<b>Benefit:</b> 75% = \$905.40	
	ORBIT, explorat	ion of anterior aspect with removal of tumour or foreign body (Anaes	s.) (Assist.)
42542	<b>Fee:</b> \$511.90	<b>Benefit:</b> 75% = \$383.95	
	ORBIT, explorat	ion of retrobulbar aspect with removal of tumour or foreign body (An	naes.) (Assist.)
42543	Fee: \$898.00	<b>Benefit:</b> 75% = \$673.50	
	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.)		
42545	Fee: \$1,298.80	<b>Benefit:</b> 75% = \$974.10	
	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.)		
42548	<b>Fee:</b> \$771.55	<b>Benefit:</b> 75% = \$578.70	
	EYE, PENETRATING WOUND OR RUPTURE OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERATIONS		9. OPHTHALMOLOGY	
	Fee: \$641.85	<b>Benefit:</b> 75% = \$481.40 85%	6 = \$557.15	
	EYE, PENETRA repair (Anaes.) (A		OF, with incarceration or prolapse of uveal tissue	
42554	<b>Fee:</b> \$748.80	<b>Benefit:</b> 75% = \$561.60		
		EYE, PENETRATING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.)		
42557	<b>Fee:</b> \$1,046.70	<b>Benefit:</b> 75% = \$785.05		
	INTRAOCULAF	FOREIGN BODY, removal from	om anterior segment (Anaes.) (Assist.)	
42563	Fee: \$527.30	<b>Benefit:</b> 75% = \$395.50 85%	6 = \$448.25	
	INTRAOCULA	R FOREIGN BODY, removal fro	om posterior segment (Anaes.) (Assist.)	
42569	<b>Fee:</b> \$1,046.70	<b>Benefit:</b> 75% = \$785.05		
	ORBITAL ABSO	CESS OR CYST, drainage of (A	naes.)	
42572	Fee: \$119.25	<b>Benefit:</b> 75% = \$89.45 85%	= \$101.40	
		orbital, excision of, on a person		
42573	Fee: \$231.10	<b>Benefit:</b> 75% = \$173.35 85%	6 = \$196.45	
.2070	DERMOID, orbital, excision of (Anaes.) (Assist.)			
42574	<b>Fee:</b> \$491.00	<b>Benefit:</b> 75% = \$368.25 85%		
72377	TARSAL CYST, extirpation of (Anaes.)			
10575		•	\$71.45	
42575	<b>Fee:</b> \$84.05 <b>Benefit:</b> 75% = \$63.05 85% = \$71.45 DERMOID, periorbital, excision of, on a person under 10 years of age (Anaes.)			
10.55		-		
42576	Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35 859 R ENTROPION, tarsal cauterisat	· +	
42581	Fee: \$119.25	<b>Benefit:</b> 75% = \$89.45 85%	= \$101.40	
	TARSORRHAPI	HY (Anaes.) (Assist.)		
42584	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95 85%		
TRICHIASIS (due to causes other tha each eyelid (Anaes.)			, treatment of by cryotherapy, laser or electrolysis -	
42587	Fee: \$52.80	<b>Benefit:</b> 75% = \$39.60 85%	= \$44.90	
	TRICHIASIS (du	e to trachoma), treatment of by	cryotherapy, laser or electrolysis - each eyelid (Anaes.)	
42588	Fee: \$52.80	<b>Benefit:</b> 75% = \$39.60 85%	= \$44.90	
	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.)			
	Fee: \$343.75	<b>Benefit:</b> 75% = \$257.85 85%	6 = \$292.20	
42590		are Safety Net Cap: \$275.00	(4)	
	LACRIMAL GL	AND, excision of palpebral lobe	(Anaes.)	
42593	Fee: \$207.85	<b>Benefit:</b> 75% = \$155.90		

T8. SUF	RGICAL OPERAT	TONS 9. OPHTHALMOLOGY	
	LACRIMAL SA	AC, excision of, or operation on (Anaes.) (Assist.)	
42596	<b>Fee:</b> \$511.90	<b>Benefit:</b> 75% = \$383.95 85% = \$435.15	
		ANALICULAR SYSTEM, establishment of patency by closed operation using silicone 1 eye (Anaes.) (Assist.)	
42599	Fee: \$641.85	<b>Benefit:</b> 75% = \$481.40 85% = \$557.15	
	LACRIMAL CA (Assist.)	ANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.)	
42602	Fee: \$641.85	<b>Benefit:</b> 75% = \$481.40 85% = \$557.15	
	LACRIMAL CA	ANALICULUS, immediate repair of (Anaes.) (Assist.)	
42605	Fee: \$473.55	<b>Benefit:</b> 75% = \$355.20 85% = \$402.55	
	LACRIMAL DI	RAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.)	
42608	Fee: \$305.55	<b>Benefit:</b> 75% = \$229.20 85% = \$259.75	
		AL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, ruction, unilateral, with or without lavage - under general anaesthesia (Anaes.)	
42610	Fee: \$97.80	<b>Benefit:</b> 75% = \$73.35 85% = \$83.15	
		AL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing bilateral, with or without lavage - under general anaesthesia (Anaes.)	
42611	Fee: \$146.65	<b>Benefit:</b> 75% = \$110.00 85% = \$124.70	
	probing to estab lavage, not bein	IAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, lish patency of the lacrimal passage and/or site of obstruction, unilateral, including g a service associated with a service to which item 42610 applies (excluding aftercare)	
42614	<b>Fee:</b> \$49.05	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$36.80 85% = \$41.70	
	to establish pate	AL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing ncy of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not associated with a service to which item 42611 applies (excluding aftercare)	
42615	Fee: \$73.40	<b>Benefit:</b> 75% = \$55.05 85% = \$62.40	
	PUNCTUM SN	IP operation (Anaes.)	
42617	Fee: \$139.15	<b>Benefit:</b> 75% = \$104.40 85% = \$118.30	
	PUNCTUM, occlusion of, by use of a plug (Anaes.)		
42620	Fee: \$53.50	<b>Benefit:</b> 75% = \$40.15 85% = \$45.50	
	PUNCTUM, per	rmanent occlusion of, by use of electrical cautery (Anaes.)	
42622	Fee: \$84.05	<b>Benefit:</b> 75% = \$63.05 85% = \$71.45	
	DACRYOCYS	TORHINOSTOMY (Anaes.) (Assist.)	
42623	<b>Fee:</b> \$710.65	<b>Benefit:</b> 75% = \$533.00	
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.)		
72020			

T8. SUF	RGICAL OPERATI	ONS	9. OPHTHALMOLOGY
	Fee: \$1,146.10	<b>Benefit:</b> 75% = \$859.60 85% = \$1061.40	
	CONJUNCTIVO (Anaes.) (Assist.)	RHINOSTOMY including dacryocystorhinosto	my and fashioning of conjunctival flaps
42629	Fee: \$863.30	<b>Benefit:</b> 75% = \$647.50	
	CONJUNCTIVA (Anaes.)	L PERITOMY OR REPAIR OF CORNEAL LA	ACERATION by conjunctival flap
42632	Fee: \$119.25	<b>Benefit:</b> 75% = \$89.45 85% = \$101.40	
	CORNEAL PERI	FORATIONS, sealing of, with tissue adhesive (	Anaes.) (Assist.)
42635	Fee: \$305.55	<b>Benefit:</b> 75% = \$229.20 85% = \$259.75	
	CONJUNCTIVA	L GRAFT OVER CORNEA (Anaes.) (Assist.)	
42638	Fee: \$382.00	<b>Benefit:</b> 75% = \$286.50 85% = \$324.70	
		CTIVAL TRANSPLANT, or mucous membrane	e graft (Anaes.) (Assist.)
42641	Fee: \$496.55	<b>Benefit:</b> 75% = \$372.45 85% = \$422.10	
12011	CORNEA OR SC	CLERA, complete removal of embedded foreign ame practitioner (excluding aftercare) (Anaes.)	body from - not more than once on the
42644	(See para TN.8.78, <b>Fee:</b> \$73.30	TN.8.4 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$55.00 85% = \$62.35	
	CORNEAL SCAL which item 42686	RS, removal of, by partial keratectomy, not being applies (Anaes.)	ng a service associated with a service to
42647	Fee: \$207.85	<b>Benefit:</b> 75% = \$155.90 85% = \$176.70	
	CORNEA, epithe	lial debridement for corneal ulcer or corneal ero	osion (excluding aftercare) (Anaes.)
42650	(See para TN.8.4 of <b>Fee:</b> \$73.30	explanatory notes to this Category) <b>Benefit:</b> 75% = \$55.00 85% = \$62.35	
	CORNEA, epithe	lial debridement for eliminating band keratopat	hy (Anaes.)
42651	Fee: \$163.35	<b>Benefit:</b> 75% = \$122.55 85% = \$138.85	
	Corneal collagen progression—per	cross linking, on a person with a corneal ectatic eye. (Anaes.)	disorder, with evidence of
42652	(See para TN.8.136 <b>Fee:</b> \$1,219.20	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$914.40 85% = \$1134.50	
	CORNEA transpl	antation of (Anaes.) (Assist.)	
42653	3 <b>Fee:</b> \$1,328.65 <b>Benefit:</b> 75% = \$996.50		
	CORNEA, transp	lantation of, second and subsequent procedures	(Anaes.) (Assist.)
42656	<b>Fee:</b> \$1,696.15	<b>Benefit:</b> 75% = \$1272.15	
	<u> </u>	antation of, full thickness, including collection	of donor material (Anaes.) (Assist.)
42662	<b>Fee:</b> \$916.75	<b>Benefit:</b> 75% = \$687.60	
72002		antation of, superficial or lamellar, including co	illection of donor material (Anaes.)
42665			

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY	
	Fee: \$611.30	<b>Benefit:</b> 75% = \$458.50 8	35% = \$526.60	
			on of, performed within 4 months of corneal grafting, to otres of astigmatism is obtained, including any associated	
42667	Fee: \$144.20	<b>Benefit:</b> 75% = \$108.15 8	35% = \$122.60	
	CORNEAL SU		than 6 weeks after operation requiring use of slit lamp or	
42668	Fee: \$76.50	<b>Benefit:</b> 75% = \$57.40 85	5% = \$65.05	
	CORNEAL INC segment surgery procedure (Anac	, including appropriate measure	gmatism of more than $1^{1/2}$ dioptres following anterior rements and calculations, performed as an independent	
42672	(See para TN.8.79 <b>Fee:</b> \$916.75	of explanatory notes to this Categ <b>Benefit:</b> 75% = \$687.60 8		
	ADDITIONAL CORNEAL INCISIONS, to correct corneal astigmatism of more than 1 <sup>1</sup> / <sub>2</sub> dioptres, including appropriate measurements and calculations, performed in conjunction with other anterior segment surgery (Anaes.) (Assist.)			
42673	Fee: \$458.30	<b>Benefit:</b> 75% = \$343.75 8	35% = \$389.60	
	CONJUNCTIVA, biopsy of, as an independent procedure		procedure	
42676	Fee: \$117.55	<b>Benefit:</b> 75% = \$88.20 85	5% = \$99.95	
	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendar which treatment is given including any associated consultation (Anaes.)			
42677	Fee: \$61.95	<b>Benefit:</b> 75% = \$46.50 85	5% = \$52.70	
	CONJUNCTIV	A, cryotherapy to, for melanotic	c lesions or similar using CO <sup>2</sup> or N <sup>2</sup> 0 (Anaes.)	
42680	Fee: \$305.55	<b>Benefit:</b> 75% = \$229.20 8	35% = \$259.75	
	CONJUNCTIVA (Anaes.)	AL CYSTS, removal of, requiri	ing admission to hospital or approved day-hospital facility	
42683	Fee: \$122.30	<b>Benefit:</b> 75% = \$91.75		
	PTERYGIUM,	removal of (Anaes.)		
42686	Fee: \$278.05	<b>Benefit:</b> 75% = \$208.55 8	35% = \$236.35	
	PINGUECULA	removal of, not being a service	re associated with the fitting of contact lenses (Anaes.)	
42689	Fee: \$119.25	<b>Benefit:</b> 75% = \$89.45 85	5% = \$101.40	
		OUR, removal of, excluding Pte		
42692	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95 8	85% = \$239.10	
LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Assist.)				
42695	Fee: \$458.30	<b>Benefit:</b> 75% = \$343.75 8	35% = \$389.60	
42698			formed for the correction of refractive error except for	

	anisometropia greater than 3 dioptres following the removal of catan	ract in the first eye (Anaes.)	
		÷ • • • • • • • • • • • • • • • • • • •	
	(See para TN.8.80 of explanatory notes to this Category) <b>Fee:</b> \$604.25 <b>Benefit:</b> 75% = \$453.20  85% = \$519.55		
	INTRAOCULAR LENS, insertion of, excluding surgery performed the error except for anisometropia greater than 3 dioptres following the (Anaes.)		
42701	(See para TN.8.80 of explanatory notes to this Category) <b>Fee:</b> \$337.00 <b>Benefit:</b> 75% = \$252.75 85% = \$286.45		
	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LE for the correction of refractive error except for anisometropia greater removal of cataract in the first eye (Anaes.)		
42702	<b>Fee:</b> \$772.80 <b>Benefit:</b> 75% = \$579.60 85% = \$688.10 <b>Extended Medicare Safety Net Cap:</b> \$115.95		
	INTRAOCULAR LENS or IRIS PROSTHESIS insertion of, into the the iris or sclera (Anaes.) (Assist.)	e posterior chamber with fixation to	
42703	<b>Fee:</b> \$581.20 <b>Benefit:</b> 75% = \$435.90 85% = \$496.50		
	INTRAOCULAR LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.)		
42704	<b>Fee:</b> \$473.55 <b>Benefit:</b> 75% = \$355.20 85% = \$402.55		
	LENS EXTRACTION AND INSERTION OF INTRAOCULAR LE for the correction of refractive error except for anisometropia greater removal of cataract in the first eye, performed in association with ins device or devices, in a patient diagnosed with open angle glaucoma topical anti-glaucoma medications or who is intolerant of anti-glaucoma.	than 3 dioptres following the sertion of a trans-trabecular drainage who is not adequately responsive to	
42705	<b>Fee:</b> \$925.70 <b>Benefit:</b> 75% = \$694.30 85% = \$841.00 <b>Extended Medicare Safety Net Cap:</b> \$138.90		
	INTRAOCULAR LENS, REMOVAL of and REPLACEMENT with performed for the correction of refractive error except for anisometro following the removal of cataract in the first eye (Anaes.)		
42707	<b>Fee:</b> \$809.85 <b>Benefit:</b> 75% = \$607.40 85% = \$725.15		
	INTRAOCULAR LENS, removal of, and replacement with a lens inserted into the posterior chamber and fixated to the iris or sclera (Anaes.) (Assist.)		
42710	<b>Fee:</b> \$916.75 <b>Benefit:</b> 75% = \$687.60 85% = \$832.05		
	IRIS SUTURING, McCannell technique or similar, for fixation of intraocular lens or repair of iris def (Anaes.) (Assist.)		
42713	<b>Fee:</b> \$382.00 <b>Benefit:</b> 75% = \$286.50 85% = \$324.70		
	CATARACT, JUVENILE, removal of, including subsequent needling	ngs (Anaes.) (Assist.)	
42716	<b>Fee:</b> \$1,214.85 <b>Benefit:</b> 75% = \$911.15 85% = \$1130.15		
	REMOVAL OF VITREOUS, and/or CAPSULAR or LENS MATERIAL, via a limbal approach, not being a service associated with a service to which item 42698, 42702, 42716, 42725 or 42731 applies (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY	
	Fee: \$527.30	<b>Benefit:</b> 75% = \$395.50 85	5% = \$448.25	
	Vitrectomy via p	ears plana sclerotomy, including	one or more of the following:	
	(a) removal of vi	treous;		
	(b) division of vi	treous bands;		
	(c) removal of ep	piretinal membranes;		
	(d) capsulotomy	(Anaes.) (Assist.)		
42725	Fee: \$1,359.85	<b>Benefit:</b> 75% = \$1019.90		
		ARS PLANA LENSECTOMY of 42702, 42719, or 42725 (Ana	combined with vitrectomy, not being a service associated es.) (Assist.)	
42731	Fee: \$1,543.30	<b>Benefit:</b> 75% = \$1157.50		
		her than by laser, and other than (Anaes.) (Assist.)	a a service associated with a service to which item 42725	
42734	Fee: \$305.55	<b>Benefit:</b> 75% = \$229.20 85	5% = \$259.75	
	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVITY, or both, for the injection of therapeutic substances, or the removal of aqueous or vitreous humours for diagnostic or therapeutic purposes, 1 or more of, as an independent procedure.  (See para TN.8.121 of explanatory notes to this Category)			
42738	Fee: \$305.55 Extended Medi	<b>Benefit:</b> 75% = \$229.20 85 care Safety Net Cap: \$244.45	5% = \$259.75	
	PARACENTES therapeutic subst	S OF ANTERIOR CHAMBER ances, or the removal of aqueou	OR VITREOUS CAVITY, or both, for the injection of as or vitreous humours for diagnostic or therapeutic dure, for a patient requiring anaesthetic services.	
	(See para TN.8.12	1 of explanatory notes to this Categ	gory)	
42739	Fee: \$305.55 Extended Medi	<b>Benefit:</b> 75% = \$229.20 85 care Safety Net Cap: \$244.45	5% = \$259.75	
	INTRAVITREA	L INJECTION OF THERAPEU	UTIC SUBSTANCES, or the removal of vitreous s a procedure associated with other intraocular surgery.	
	(See para TN.8.121 of explanatory notes to this Category) <b>Fee:</b> \$305.55 <b>Benefit:</b> 75% = \$229.20 85% = \$259.75			
42740		care Safety Net Cap: \$244.45		
	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.)			
42741	(See para TN.8.81 <b>Fee:</b> \$305.55	of explanatory notes to this Categorana Benefit: 75% = \$229.20 85		
			LOOD FROM, as an independent procedure (Anaes.)	
42743	<b>Fee:</b> \$641.85	<b>Benefit:</b> 75% = \$481.40 85	5% - \$557.15	

T8. SUF	RGICAL OPERATION	ONS 9. OPHTHALMOLOGY		
	Needle revision o	f glaucoma filtration bleb, following glaucoma filtering procedure (Anaes.)		
42744	Fee: \$305.35	<b>Benefit:</b> 75% = \$229.05 85% = \$259.55		
	GLAUCOMA, fill contraindicated (A	tering operation for, where conservative therapies have failed, are likely to fail, or are Anaes.) (Assist.)		
42746	Fee: \$970.30	<b>Benefit:</b> 75% = \$727.75		
	GLAUCOMA, fil (Assist.)	tering operation for, where previous filtering operation has been performed (Anaes.)		
42749	Fee: \$1,214.85	<b>Benefit:</b> 75% = \$911.15		
	GLAUCOMA, in device (Anaes.) (A	sertion of drainage device incorporating an extraocular reservoir for, such as a Molteno Assist.)		
42752	(See para TN.8.83 o <b>Fee:</b> \$1,359.85	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$1019.90		
	GLAUCOMA, re device (Anaes.)	moval of drainage device incorporating an extraocular reservoir for, such as a Molteno		
42755	Fee: \$168.10	<b>Benefit:</b> 75% = \$126.10 85% = \$142.90		
	Goniotomy for the treatment of primary congenital glaucoma, excluding the minimally invasive implantation of glaucoma drainage devices (Anaes.) (Assist.)			
42758	<b>Fee:</b> \$710.65	<b>Benefit:</b> 75% = \$533.00		
	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.)			
42761	<b>Fee:</b> \$527.30	<b>Benefit:</b> 75% = \$395.50 85% = \$448.25		
		ncluding excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, r (Anaes.) (Assist.)		
42764	Fee: \$527.30	<b>Benefit:</b> 75% = \$395.50 85% = \$448.25		
	TUMOUR, INVO (Assist.)	DLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.)		
42767	<b>Fee:</b> \$1,107.80	<b>Benefit:</b> 75% = \$830.85		
	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)			
42770	(See para TN.8.82 of explanatory notes to this Category) <b>Fee:</b> \$299.50 <b>Benefit:</b> 75% = \$224.65 85% = \$254.60			
	DETACHED RETINA, pneumatic retinopexy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.)			
42773	Fee: \$916.75	<b>Benefit:</b> 75% = \$687.60 85% = \$832.05		
	DETACHED RE	ΓΙΝΑ, buckling or resection operation for (Anaes.) (Assist.)		
42776	Fee: \$1,359.85	<b>Benefit:</b> 75% = \$1019.90		
	DETACHED RE	TINA, revision of scleral buckling operation for (Anaes.) (Assist.)		
42779	<b>Fee:</b> \$1,696.15	<b>Benefit:</b> 75% = \$1272.15		

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
		CULOPLASTY, for the treat of that eye in a 2 year period (	atment of glaucoma. Each treatment to 1 eye, to a maximum (Anaes.) (Assist.)
42782	(See para TN.8.84 <b>Fee:</b> \$458.30	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$343.75	
	LASER IRIDOT year period (Ana		ode to 1 eye, to a maximum of 3 treatments to that eye in a 2
42785	(See para TN.8.85 <b>Fee:</b> \$359.00	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$269.25	•
			to one eye, to a maximum of 2 treatments to that eye in a 2 with a service to which item 42702 applies (Anaes.)
42788	(See para TN.8.86 <b>Fee:</b> \$359.00	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$269.25	
		each treatment to one eye, to	rial or fibrinolysis, excluding vitreolysis in the posterior to a maximum of 3 treatments to that eye in a 2 year period
42791	(See para TN.8.87 <b>Fee:</b> \$359.00	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$269.25	•
	DIVISION OF SUTURE BY LASER following glaucoma filtration surgery, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.)		
42794	(See para TN.8.88 <b>Fee:</b> \$68.75	of explanatory notes to this Cate <b>Benefit:</b> 75% = \$51.60	- ·
		ADIOACTIVE PLAQUE (Romas, insertion of (Anaes.) (A	Ruthenium 106 or Iodine 125), for the treatment of (Assist.)
42801	Fee: \$1,066.50	<b>Benefit:</b> 75% = \$799.90	
		ADIOACTIVE PLAQUE (Romas, removal of (Anaes.) (A	Ruthenium 106 or Iodine 125), for the treatment of Assist.)
42802	<b>Fee:</b> \$533.10	<b>Benefit:</b> 75% = \$399.85	
			n to the sclera to localise the tumour base to assist in omas, 1 or more (Anaes.) (Assist.)
42805	Fee: \$595.90	<b>Benefit:</b> 75% = \$446.95	85% = \$511.20
	IRIS TUMOUR,	laser photocoagulation of (A	Anaes.) (Assist.)
42806	Fee: \$359.00	<b>Benefit:</b> 75% = \$269.25	85% = \$305.15
PHOTOMYDRIASIS, laser		ASIS, laser	
42807	<b>Fee:</b> \$361.50	<b>Benefit:</b> 75% = \$271.15	85% = \$307.30
	Laser peripheral		
42808	<b>Fee:</b> \$361.50	<b>Benefit:</b> 75% = \$271.15	85% = \$307.30
		coagulation of, not being a sec	ervice associated with photodynamic therapy with
42809	Fee: \$458.30	<b>Benefit:</b> 75% = \$343.75	85% - \$389.60

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	PHOTOTHERA for refractive error	PEUTIC KERATECTOMY, by laser, for corneal scarring or (Anaes.)	or disease, excluding surgery
42810	Fee: \$576.80	<b>Benefit:</b> 75% = \$432.60 85% = \$492.10	
	TRANSPUPILL malformations (A	ARY THERMOTHERAPY, for treatment of choroidal an Anaes.)	d retinal tumours or vascular
42811	<b>Fee:</b> \$458.30	<b>Benefit:</b> 75% = \$343.75 85% = \$389.60	
	Removal of scler (Anaes.)	ral buckling material, from an eye having undergone previ	ous scleral buckling surgery
42812	<b>Fee:</b> \$168.10	<b>Benefit:</b> 75% = \$126.10 85% = \$142.90	
		VITY, removal of silicone oil or other liquid vitreous substitute in which the vitreous substitute is inserted (Anae	
42815	Fee: \$641.85	<b>Benefit:</b> 75% = \$481.40	
	RETINA, CRYC item 42809 or 42	OTHERAPY TO, as an independent procedure, or when per 2770 (Anaes.)	erformed in conjunction with
42818	<b>Fee:</b> \$595.90	<b>Benefit:</b> 75% = \$446.95 85% = \$511.20	
	OCULAR TRAN (Anaes.)	NSILLUMINATION, for the diagnosis and measurement of	of intraocular tumours
42821	Fee: \$91.80	<b>Benefit:</b> 75% = \$68.85 85% = \$78.05	
	RETROBULBA	R INJECTION OF ALCOHOL OR OTHER DRUG, as ar	n independent procedure
42824	Fee: \$71.00	<b>Benefit:</b> 75% = \$53.25 85% = \$60.35	
		ATION FOR, ON 1 OR BOTH EYES, the operation invo patient aged 15 years or over (Anaes.) (Assist.)	lving a total of 1 OR 2
42833	Fee: \$595.90	<b>Benefit:</b> 75% = \$446.95	
	MUSCLES, on a	ATION FOR, ON 1 OR BOTH EYES, the operation involution and patient aged 14 years or under, or where the patient has heations on the eye or eyes, or on a patient with concurrent to	nad previous squint, retinal or
42836	Fee: \$741.10	<b>Benefit:</b> 75% = \$555.85	
	-	ATION FOR, ON 1 OR BOTH EYES, the operation invopatient aged 15 years or over (Anaes.) (Assist.)	lving a total of 3 OR MORE
42839	<b>Fee:</b> \$710.65	<b>Benefit:</b> 75% = \$533.00	
	MUSCLES, on a	ATION FOR, ON 1 OR BOTH EYES, the operation involution and patient aged 14 years or under, or where the patient has had ations on the eye or eyes, or on a patient with concurrent to	and previous squint, retinal or
42842	Fee: \$886.25	<b>Benefit:</b> 75% = \$664.70	
		NT OF ADJUSTABLE SUTURES, 1 or both eyes, as an i tration for correction of squint (Anaes.)	ndependent procedure
42845	(See para TN.8.89	of explanatory notes to this Category)	

T8. SUF	RGICAL OPERAT	IONS	9. OPHTHALMOLOGY
	Fee: \$192.45	<b>Benefit:</b> 75% = \$144.35	85% = \$163.60
	SQUINT, muscle over (Anaes.) (A	-	im type, or similar operation) on a patient aged 15 years or
42848	<b>Fee:</b> \$710.65	<b>Benefit:</b> 75% = \$533.00	
	under, or where		im type, or similar operation) on a patient aged 14 years or squint, retinal or extra ocular operations on the eye or eyes, sease (Anaes.) (Assist.)
42851	Fee: \$886.25	<b>Benefit:</b> 75% = \$664.70	
	RUPTURED MI (Anaes.) (Assist.		MENT or ruptured EXTRAOCULAR MUSCLE, repair of
42854	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	85% = \$350.70
		OF WOUND FOLLOWING psed iris (Anaes.) (Assist.)	INTRAOCULAR PROCEDURES with or without
42857	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	85% = \$350.70
	EYELID (upper retractors (Anaes		or other non-autogenous graft to, with recession of the lid
42860	<b>Fee:</b> \$916.75	<b>Benefit:</b> 75% = \$687.60	85% = \$832.05
	EYELID, recess	on of (Anaes.) (Assist.)	
42863	Fee: \$786.95	<b>Benefit:</b> 75% = \$590.25	85% = \$702.25
		TARSAL ECTROPION, re	pair of, by tightening, shortening or repair of inferior width of the eyelid (Anaes.) (Assist.)
42866	<b>Fee:</b> \$763.90	<b>Benefit:</b> 75% = \$572.95	85% = \$679.20
	EYELID closure	in facial nerve paralysis, ins	ertion of foreign implant for (Anaes.) (Assist.)
42869	<b>Fee:</b> \$557.80	<b>Benefit:</b> 75% = \$418.35	85% = \$474.15
	EYEBROW, elevation of, by skin excision, to correct for a reduced field of vision caused by paretic, involutional, or traumatic eyebrow descent/ptosis to a position below the superior orbital rim (Anaes.)		
42872	Fee: \$244.55	<b>Benefit:</b> 75% = \$183.45	85% = \$207.90
	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.		
43021	Fee: \$462.35	<b>Benefit:</b> 75% = \$346.80	85% = \$393.00
	Photodynamic therapy, both eyes, including the infusion of Verteporfin continuously through a peripheral vein, using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal neovascularisation.		
43022	Fee: \$554.90	<b>Benefit:</b> 75% = \$416.20	85% = \$471.70
			odynamic therapy, where a session of therapy which would 22 has been discontinued on medical grounds.
43023	Fee: \$89.90	<b>Benefit:</b> 75% = \$67.45	85% = \$76.45

	GICAL OPERATIONS 10. OPERATIONS FOR OSTEOMYELITIS			
	Group T8. Surgical Operations			
	Subgroup 10. Operations For Osteomyelitis			
	ACUTE			
	OPERATION ON PHALANX (Anaes.)			
43500	<b>Fee:</b> \$125.30 <b>Benefit:</b> 75% = \$94.00			
	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.)			
43503	<b>Fee:</b> \$208.00 <b>Benefit:</b> 75% = \$156.00			
	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)			
43506	<b>Fee:</b> \$362.05 <b>Benefit:</b> 75% = \$271.55			
	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)			
43509	<b>Fee:</b> \$362.05 <b>Benefit:</b> 75% = \$271.55			
	CHRONIC			
	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.)			
43512	<b>Fee:</b> \$362.05 <b>Benefit:</b> 75% = \$271.55			
	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)			
43515	<b>Fee:</b> \$362.05 <b>Benefit:</b> 75% = \$271.55 85% = \$307.75			
	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)			
43518	<b>Fee:</b> \$597.00 <b>Benefit:</b> 75% = \$447.75			
	OPERATION ON SKULL (Anaes.) (Assist.)			
43521	<b>Fee:</b> \$471.95 <b>Benefit:</b> 75% = \$354.00			
	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.)			
43524	<b>Fee:</b> \$597.00 <b>Benefit:</b> 75% = \$447.75 85% = \$512.30			
T8. SUF	GICAL OPERATIONS 11. PAEDIATRIC			
	Group T8. Surgical Operations			
	Subgroup 11. Paediatric			
	SURGERY IN NEONATE OR YOUNG CHILD			
	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.)			

T8. SUF	RGICAL OPERATION	DNS 11. PAEDIATRIC
		ALROTATION with or without volvulus, laparotomy for, with bowel resection and
	anastomosis, with	or without formation of stoma (Anaes.) (Assist.)
43804	Fee: \$1,035.55	<b>Benefit:</b> 75% = \$776.70
	UMBILICAL, EP (Anaes.)	IGASTRIC OR LINEA ALBA HERNIA, repair of, on a person under 10 years of age
43805	Fee: \$362.05	<b>Benefit:</b> 75% = \$271.55
	DUODENAL AT (Assist.)	RESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.)
43807	Fee: \$1,129.80	<b>Benefit:</b> 75% = \$847.35
	JEJUNAL ATRE	SIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.)
43810	<b>Fee:</b> \$1,318.10	<b>Benefit:</b> 75% = \$988.60
		US, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinar without meconium peritonitis (Anaes.) (Assist.)
43813	Fee: \$1,318.10	<b>Benefit:</b> 75% = \$988.60
		, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with item 43813 applies, laparotomy for (Anaes.) (Assist.)
43816	Fee: \$1,223.85	<b>Benefit:</b> 75% = \$917.90
	Agangliosis Coli, (Anaes.) (Assist.)	laparotomy for, with or without frozen section biopsies and formation of stoma
43819	<b>Fee:</b> \$988.50	<b>Benefit:</b> 75% = \$741.40
	ANORECTAL M	ALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)
43822	Fee: \$988.50	<b>Benefit:</b> 75% = \$741.40
		MENTARY OBSTRUCTION, laparotomy for, not being a service to which any other oup applies (Anaes.) (Assist.)
43825	Fee: \$1,129.80	<b>Benefit:</b> 75% = \$847.35
		TAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including or stoma formation (Anaes.) (Assist.)
43828	Fee: \$1,248.20	<b>Benefit:</b> 75% = \$936.15
	ACUTE NEONA laparotomy for (A	TAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, naes.) (Assist.)
43831	Fee: \$972.60	<b>Benefit:</b> 75% = \$729.45
	BRANCHIAL FI	STULA, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)
43832	<b>Fee:</b> \$663.40	<b>Benefit:</b> 75% = \$497.55
	+	TION for necrotising enterocolitis stricture or strictures, including any anastomoses or
43834	<b>Fee:</b> \$1,129.80	<b>Benefit:</b> 75% = \$847.35
43835		D, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel

T8. SUF	RGICAL OPERATION	DNS 11. PAEDIATRIC
	resection, on a per	son under 10 years of age (Anaes.) (Assist.)
	Fee: \$688.50	<b>Benefit:</b> 75% = \$516.40
		IAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with ed in the first 24 hours of life (Anaes.) (Assist.)
43837	Fee: \$1,412.15	<b>Benefit:</b> 75% = \$1059.15
		nia, congential repair of, by thoracic or abdominal approach, not being a service to s 31569 to 31581 apply, on a person under 10 years of age (Anaes.) (Assist.)
43838	Fee: \$1,264.40	<b>Benefit:</b> 75% = \$948.30
		IAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed of life and before 20 days of age (Anaes.) (Assist.)
43840	Fee: \$1,223.85	<b>Benefit:</b> 75% = \$917.90
		IGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to or 43835 applies, on a person under 10 years of age (Anaes.) (Assist.)
43841	<b>Fee:</b> \$613.50	<b>Benefit:</b> 75% = \$460.15
		ATRESIA (with or without repair of tracheo-oesophageal fistula), complete being a service to which item 43846 applies (Anaes.) (Assist.)
43843	Fee: \$1,883.00	<b>Benefit:</b> 75% = \$1412.25
		ATRESIA (with or without repair of tracheo-oesophageal fistula), complete fant of birth weight less than 1500 grams (Anaes.) (Assist.)
43846	Fee: \$2,024.20	<b>Benefit:</b> 75% = \$1518.15
	OESOPHAGEAL	ATRESIA, gastrostomy for (Anaes.) (Assist.)
43849	<b>Fee:</b> \$517.80	<b>Benefit:</b> 75% = \$388.35
	OESOPHAGEAL anastomosis (Ana	ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without es.) (Assist.)
43852	<b>Fee:</b> \$1,647.50	<b>Benefit:</b> 75% = \$1235.65
	OESOPHAGEAL	ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.)
43855	Fee: \$1,741.80	<b>Benefit:</b> 75% = \$1306.35
	OESOPHAGEAL	ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.)
43858	<b>Fee:</b> \$611.90	<b>Benefit:</b> 75% = \$458.95
	CONGENITAL C	YSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR toracotomy and lung resection for (Anaes.) (Assist.)
43861	Fee: \$1,694.75	<b>Benefit:</b> 75% = \$1271.10
	GASTROSCHISI	S, operation for (Anaes.) (Assist.)
43864	Fee: \$1,271.05	<b>Benefit:</b> 75% = \$953.30
	·	S or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.)
43867	<b>Fee:</b> \$706.10	<b>Benefit:</b> 75% = \$529.60
15001	1 00. φ/00.10	Delicate 10 /0 - ψ0 27.00

T8. SUF	RGICAL OPERATI	ONS 11. PAEDIATRIC		
	EXOMPHALOS	containing small bowel only, operation for (Anaes.) (Assist.)		
43870	Fee: \$988.50	<b>Benefit:</b> 75% = \$741.40		
43070	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.)			
		containing sinan bower and other viscera, operation for (vinces.) (vissist.)		
43873	Fee: \$1,318.10	<b>Benefit:</b> 75% = \$988.60		
	SACROCOCCYO	GEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.)		
43876	Fee: \$1,129.80	<b>Benefit:</b> 75% = \$847.35		
	SACROCOCCY (Anaes.) (Assist.)	GEAL TERATOMA, excision of, by combined posterior and abdominal approach		
43879	Fee: \$1,318.10	<b>Benefit:</b> 75% = \$988.60		
	CLOACAL EXS	TROPHY, operation for (Anaes.) (Assist.)		
43882	<b>Fee:</b> \$1,694.75	<b>Benefit:</b> 75% = \$1271.10 85% = \$1610.05		
13002	100. \$1,00 1.75	THORACIC SURGERY		
	TRACHEO-OES	OPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.)		
43900	<b>Fee:</b> \$1,129.80	<b>Benefit:</b> 75% = \$847.35		
43900	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.)			
12002				
43903	Fee: \$1,883.00	Benefit: 75% = \$1412.25		
		resection of congenital, anastomic or corrosive stricture and anastomosis, not being a item 43903 applies (Anaes.) (Assist.)		
12006	East #1 647 50	Dan 64, 750/ 01025 (5		
43906	Fee: \$1,647.50	Benefit: 75% = \$1235.65 ACIA, aortopexy for (Anaes.) (Assist.)		
	TRACTIEOWAL	ACIA, autropexy for (Aliaes.) (Assist.)		
43909	<b>Fee:</b> \$1,647.50	<b>Benefit:</b> 75% = \$1235.65		
	THORACOTOM teratoma (Anaes.)	(Y and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal (Assist.)		
43912	Fee: \$1,556.50	<b>Benefit:</b> 75% = \$1167.40		
	EVENTRATION	, plication of diaphragm for (Anaes.) (Assist.)		
43915	Fee: \$1,176.85	<b>Benefit:</b> 75% = \$882.65		
		ABDOMINAL SURGERY		
	HYPERTROPHI	C PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.)		
43930	Fee: \$452.55	<b>Benefit:</b> 75% = \$339.45		
-r3/3U		TUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.)		
43933	Fee: \$529.75	<b>Benefit:</b> 75% = \$397.35		
	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.)			
43936	Fee: \$988.50	<b>Benefit:</b> 75% = \$741.40		
43939	VENTRAL HER	NIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.)		

T8. SUF	RGICAL OPERAT	IONS 11. PAEDIATRIC		
	(Assist.)			
	<b>Fee:</b> \$753.15	<b>Benefit:</b> 75% = \$564.90		
		WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.)		
43942	Fee: \$235.40	<b>Benefit:</b> 75% = \$176.55		
43742		LLO INTESTINAL DUCT, excision of (Anaes.) (Assist.)		
100.15				
43945	Fee: \$988.50	Benefit: 75% = \$741.40		
	UMBILICAL G.	RANULOMA, excision of, under general anaesthesia (Anaes.)		
43948	Fee: \$141.35	<b>Benefit:</b> 75% = \$106.05		
		DPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, omy (Anaes.) (Assist.)		
	without gastroste	omy (Alides.) (Assist.)		
43951	Fee: \$885.25	<b>Benefit:</b> 75% = \$663.95		
		PPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, (Anaes.) (Assist.)		
43954	Fee: \$1,082.80	<b>Benefit:</b> 75% = \$812.10		
		PHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or ernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)		
43957	Fee: \$1,176.85	<b>Benefit:</b> 75% = \$882.65		
	ANORECTAL N	MALFORMATION, perineal anoplasty of (Anaes.) (Assist.)		
43960	<b>Fee:</b> \$414.00	<b>Benefit:</b> 75% = \$310.50		
	ANORECTAL N	MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)		
43963	<b>Fee:</b> \$1,647.50	<b>Benefit:</b> 75% = \$1235.65		
43703	· ·	MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.)		
	(Assist.)			
43966	Fee: \$1,883.00	<b>Benefit:</b> 75% = \$1412.25		
		LOACA, total correction of, with genital repair using posterior sagittal approach, with otomy (Anaes.) (Assist.)		
43969	Fee: \$2,589.10	<b>Benefit:</b> 75% = \$1941.85		
	CHOLEDOCHA	AL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)		
43972	Fee: \$1,883.00	<b>Benefit:</b> 75% = \$1412.25		
43712	· ·	AL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)		
105=-				
43975	Fee: \$2,212.55	<b>Benefit:</b> 75% = \$1659.45		
	BILIARY ATRESIA, portoenterostomy for (Anaes.) (Assist.)			
43978	Fee: \$1,883.00	<b>Benefit:</b> 75% = \$1412.25		
42001		TOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy		
43981	(exploratory), in	cluding associated biopsies, where no other intra-abdominal procedure is performed		

T8. SUF	RGICAL OPERATION	DNS 11. PAEDIATRIC
	(Anaes.) (Assist.)	
	<b>Fee:</b> \$517.80	<b>Benefit:</b> 75% = \$388.35
	NEPHROBLASTO	OMA, radical nephrectomy for (Anaes.) (Assist.)
43984	<b>Fee:</b> \$1,318.10	<b>Benefit:</b> 75% = \$988.60
	NEUROBLASTO	MA, radical excision of (Anaes.) (Assist.)
43987	<b>Fee:</b> \$1,459.40	<b>Benefit:</b> 75% = \$1094.55
		i, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends to sigmoid colon (Anaes.) (Assist.)
43990	Fee: \$1,788.90	<b>Benefit:</b> 75% = \$1341.70
		i, definitive resection with pull-through anastomosis, with or without frozen section anglionic segment extends into descending or transverse colon with or without resiting (Assist.)
43993	Fee: \$1,930.05	<b>Benefit:</b> 75% = \$1447.55
		i, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or e ileocolic anastomosis (Anaes.) (Assist.)
43996	Fee: \$2,165.45	<b>Benefit:</b> 75% = \$1624.10
	Aganglionosis Col	i, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)
43999	Fee: \$270.80	<b>Benefit:</b> 75% = \$203.10
		nation of, on a person under 2 years of age, under general anaesthesia with full r removal of polyp or similar lesion (Anaes.) (Assist.)
44101	Fee: \$339.40	<b>Benefit:</b> 75% = \$254.55
		nation of, on a person 2 years of age or over, under general anaesthesia with full r removal of polyp or similar lesion (Anaes.) (Assist.)
44102	Fee: \$261.05	<b>Benefit:</b> 75% = \$195.80
	RECTAL PROLA under general anae	PSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, esthesia (Anaes.)
44104	Fee: \$59.60	<b>Benefit:</b> 75% = \$44.70 85% = \$50.70
	RECTAL PROLA under general anae	PSE, SUBMUCOSAL or perirectal injection for, on a person 2 years of age or over, esthesia (Anaes.)
44105	<b>Fee:</b> \$45.80	<b>Benefit:</b> 75% = \$34.35 85% = \$38.95
	INGUINAL HERN	NIA repair at age less than 12 months (Anaes.) (Assist.)
44108	<b>Fee:</b> \$499.30	<b>Benefit:</b> 75% = \$374.50
		PR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months bexy when performed (Anaes.) (Assist.)
44111	Fee: \$584.85	<b>Benefit:</b> 75% = \$438.65 85% = \$500.15
44114	INGUINAL HERM (Assist.)	NIA repair at age less than 12 months when orchidopexy also required (Anaes.)

T8. SUI	RGICAL OPERAT	IONS 11. PAEDIATRIC		
	Fee: \$584.85	<b>Benefit:</b> 75% = \$438.65		
		MISCELLANEOUS SURGERY		
	LYMPHADENE (Assist.)	ECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.)		
44130	Fee: \$470.70	<b>Benefit:</b> 75% = \$353.05 85% = \$400.10		
	TORTICOLLIS,	open division of sternomastoid muscle for (Anaes.) (Assist.)		
44133	Fee: \$373.65	<b>Benefit:</b> 75% = \$280.25		
	INGROWN TO	E NAIL, operation for, under general anaesthesia (Anaes.)		
44136	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15 85% = \$146.40		
T8. SUI	RGICAL OPERAT	IONS 12. AMPUTATIONS		
	Group T8. Surg	ical Operations		
		Subgroup 12. Amputations		
	HAND, MIDCA	RPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.)		
44325	Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35 85% = \$255.40		
	HAND, FOREA	RM OR THROUGH ARM, amputation of (Anaes.) (Assist.)		
44328	Fee: \$362.05	<b>Benefit:</b> 75% = \$271.55		
	AMPUTATION	AT SHOULDER (Anaes.) (Assist.)		
44331	Fee: \$597.00	<b>Benefit:</b> 75% = \$447.75		
	INTERSCAPUL	OTHORACIC AMPUTATION (Anaes.) (Assist.)		
44334	Fee: \$1,213.35	<b>Benefit:</b> 75% = \$910.05 85% = \$1128.65		
	1 DIGIT of foot,	amputation of (Anaes.)		
44338	Fee: \$146.30	<b>Benefit:</b> 75% = \$109.75 85% = \$124.40		
	2 DIGITS of 1 fo	oot, amputation of (Anaes.)		
44342	Fee: \$223.45	<b>Benefit:</b> 75% = \$167.60		
	3 DIGITS of 1 fo	oot, amputation of (Anaes.) (Assist.)		
44346	Fee: \$258.05	<b>Benefit:</b> 75% = \$193.55		
	4 DIGITS of 1 fo	oot, amputation of (Anaes.) (Assist.)		
44350	Fee: \$292.80	<b>Benefit:</b> 75% = \$219.60 85% = \$248.90		
	5 DIGITS of 1 fo	oot, amputation of (Anaes.) (Assist.)		
44354	Fee: \$335.10	<b>Benefit:</b> 75% = \$251.35		
	TOE, including metatarsal or part of metatarsal each toe, amputation of (Anaes.)			
44358	Fee: \$186.85	<b>Benefit:</b> 75% = \$140.15		
	ONE OR MORE	TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more		
44359	metatarsal bones	of the foot, performed for diabetic or other microvascular disease, excluding aftercare		

T8. SUF	RGICAL OPERAT	ONS 12. AMPUTATION	
	(Anaes.) (Assist.		
	Fee: \$268.15	<b>Benefit:</b> 75% = \$201.15	
	FOOT AT ANK	E (Syme, Pirogoff types), amputation of (Anaes.) (Assist.)	
44361	Fee: \$362.05	<b>Benefit:</b> 75% = \$271.55	
	FOOT, MIDTAI	SAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.)	
44364	Fee: \$300.45	<b>Benefit:</b> 75% = \$225.35	
	AMPUTATION	THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.)	
44367	<b>Fee:</b> \$530.30	<b>Benefit:</b> 75% = \$397.75	
	AMPUTATION	AT HIP (Anaes.) (Assist.)	
44370	<b>Fee:</b> \$731.70	<b>Benefit:</b> 75% = \$548.80	
		, amputation of (Anaes.) (Assist.)	
44373	<b>Fee:</b> \$1,502.05	<b>Benefit:</b> 75% = \$1126.55 85% = \$1417.35	
	- '	STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.)	
44376	Derived Fee: 75	o of the original amputation fee	
	RGICAL OPERAT		
10.00.			
	Group T8. Surg	al Operations	
	Subgroup 13. Plastic And Reconstructive Surgery  GENERAL		
	Single stage local muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals not in association with any of items 31356 to 31376 (Anaes.)		
45000	Fee: \$550.00	<b>Benefit:</b> 75% = \$412.50 85% = \$467.50	
		myocutaneous flap repair to one defect, simple and small not in association with any 31376 (Anaes.)	
45003	Fee: \$611.30 Extended Medic	<b>Benefit:</b> 75% = \$458.50 85% = \$526.60 are <b>Safety Net Cap:</b> \$489.05	
	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimu dorsi, or similar large muscle) (Anaes.) (Assist.)		
45006	Fee: \$1,054.25	<b>Benefit:</b> 75% = \$790.70	
	SINGLE STAGE	LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.)	
45009	<b>Fee:</b> \$385.10	<b>Benefit:</b> 75% = \$288.85	
	SINGLE STAGE	LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, large muscle) (Anaes.) (Assist.)	
45012	<b>Fee:</b> \$645.15	<b>Benefit:</b> 75% = \$483.90	
45015		OCUTANEOUS FLAP, delay of (Anaes.)	

T8. SUF	GICAL OPERATION	IS	13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	Fee: \$305.55	<b>Benefit:</b> 75% = \$229.20			
			ransfer of fat by injection), if the service is not associated ers mentioned in any of items 51011 to 51171 (Anaes.)		
45018	Fee: \$481.25	<b>Benefit:</b> 75% = \$360.95	85% = \$409.10		
	Full face chemical p	eel for severely sun-dam	aged skin, if:		
	(a) the damage affec	ts at least 75% of the fac	ial skin surface area; and		
	(b) the damage involves photo-damage (dermatoheliosis); and				
	(c) the photo-damage	e involves:			
	(i) a solar kerat	osis load exceeding 30 i	ndividual lesions; or		
	(ii) solar lentig	ines; or			
	(iii) freckling,	yellowing or leathering o	of the skin; or		
	(iv) solar kerto	ses which have proven re	efractory to, or recurred following, medical therapies; and		
	(d) at least medium depth peeling agents are used; and				
	(e) the chemical peel is performed in the operating theatre of a hospital by a medical practitioner recognised as a specialist in the specialty of dermatology or plastic surgery.				
	Applicable once only	y in any 12 month period	(Anaes.)		
45019	Fee: \$403.05	<b>Benefit:</b> 75% = \$302.30			
	ABRASIVE THERA to 1 aesthetic area (A	• •	ring scarring resulting from trauma, burns or acne - limited		
45021	(See para TN.8.91 of explanatory notes to this Category) <b>Fee:</b> \$180.20 <b>Benefit:</b> 75% = \$135.15 85% = \$153.20				
	ABRASIVE THERA than 1 aesthetic area	• •	ring scarring resulting from trauma, burns or acne - more		
45024	(See para TN.8.91 of e <b>Fee:</b> \$404.95	xplanatory notes to this Cat Benefit: 75% = \$303.75			
		or severely disfiguring so	LASER (not including fractional laser therapy) resurfacing carring resulting from trauma, burns or acne - limited to 1		
45025	(See para TN.8.91 of explanatory notes to this Category) <b>Fee:</b> \$180.20 <b>Benefit:</b> 75% = \$135.15 85% = \$153.20 <b>Extended Medicare Safety Net Cap:</b> \$144.20				
<del>1</del> 3023	CARBON DIOXIDI	E LASER OR ERBIUM or severely disfiguring so	LASER (not including fractional laser therapy) resurfacing carring resulting from trauma, burns or acne - more than 1		
45026	<b>Fee:</b> \$404.95	xplanatory notes to this Cat Benefit: 75% = \$303.75 Safety Net Cap: \$324.0	85% = \$344.25		

T8. SURGICAL OPERATIONS		NS	13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	ANGIOMA, cauter (Anaes.)	isation of or injection int	o, where undertaken in the operating theatre of a hospital		
45027	Fee: \$122.30	<b>Benefit:</b> 75% = \$91.75	85% = \$104.00		
			na or both) of skin and subcutaneous tissue (excluding facial excision and suture of (Anaes.)		
45030	Fee: \$131.30	<b>Benefit:</b> 75% = \$98.50	85% = \$111.65		
		angioma or lymphangior cision and suture of (An	ma or both), large or involving deeper tissue including facial aes.)		
45033	Fee: \$244.55	<b>Benefit:</b> 75% = \$183.45	85% = \$207.90		
	ANGIOMA (haema excision of (Anaes.)		na or both), large and deep, involving muscles or nerves,		
45035	Fee: \$713.30	<b>Benefit:</b> 75% = \$535.00			
	ANGIOMA (haema	ngioma or lymphangion	na or both) of neck, deep, excision of (Anaes.) (Assist.)		
45036	Fee: \$1,146.10	<b>Benefit:</b> 75% = \$859.60			
	ARTERIOVENOU (Anaes.)	S MALFORMATION (3	3 centimetres or less) of superficial tissue, excision of		
45039	Fee: \$244.55	<b>Benefit:</b> 75% = \$183.45	85% = \$207.90		
	ARTERIOVENOU	S MALFORMATION, (	greater than 3 centimetres), excision of (Anaes.) (Assist.)		
45042	Fee: \$313.35	<b>Benefit:</b> 75% = \$235.05	85% = \$266.35		
	ARTERIOVENOU excision of (Anaes.)		n eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals,		
45045	Fee: \$313.35	<b>Benefit:</b> 75% = \$235.05	85% = \$266.35		
		TOUS tissue or lymphan najor excision of (Anaes	giectasis, of lower leg and foot, or thigh, or upper arm, or .) (Assist.)		
45048	Fee: \$786.95	<b>Benefit:</b> 75% = \$590.25			
	Contour reconstruction by open repair of contour defects, due to deformity, if:				
	(a) contour reconstructive surgery is indicated because the deformity is secondary to congenital absence of tissue or has arisen from trauma (other than trauma from previous cosmetic surgery); and				
	(b) insertion of a non-biological implant is required, other than one or more of the following:				
	(i) insertion of a non-biological implant that is a component of another service specified in Group T8;				
	(ii) injection of liquid or semisolid material;				
	(iii) an oral and maxillofacial implant service to which item 52321 applies;				
	(iv) a service to insert mesh; and				
45051	(c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)				

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	<b>Fee:</b> \$481.35 <b>Benefit:</b> 75% = \$361.05
	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.)
45054	(See para TN.8.92 of explanatory notes to this Category) <b>Fee:</b> \$250.05 <b>Benefit:</b> 75% = \$187.55
	Developmental breast abnormality, single stage correction of, if:
	(a) the correction involves either:
	(i) bilateral mastopexy for symmetrical tubular breasts; or
	(ii) surgery on both breasts with a combination of insertion of one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least 20% in normally shaped breasts, or 10% in tubular breasts or in breasts with abnormally high inframammary folds; and
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes
	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)
45060	<b>Fee:</b> \$1,291.65 <b>Benefit:</b> 75% = \$968.75
	Developmental breast abnormality, 2 stage correction of, first stage, involving surgery on both breasts with a combination of insertion of one or more tissue expanders, mastopexy or reduction mammaplasty, if:
	(a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:
	(i) 20% in normally shaped breasts; or
	(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.
	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)
45061	<b>Fee:</b> \$1,291.65 <b>Benefit:</b> 75% = \$968.75
	Developmental breast abnormality, 2 stage correction of, second stage, involving surgery on both breasts with a combination of exchange of one or more tissue expanders for one or more implants (which must have at least a 10% volume difference), mastopexy or reduction mammaplasty, if:
	(a) there is a difference in breast volume, as demonstrated by an appropriate volumetric measurement technique, of at least:
	(i) 20% in normally shaped breasts; or
	(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds; and
45062	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes.
45062	documented in the patient notes.

T8. SUR	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)
	<b>Fee:</b> \$934.70 <b>Benefit:</b> 75% = \$701.05
	SKIN FLAP SURGERY
	Single stage local flap, if indicated to repair one defect, simple and small, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.)
45200	(See para TN.8.93 of explanatory notes to this Category) <b>Fee:</b> \$288.90 <b>Benefit:</b> 75% = \$216.70 85% = \$245.60 <b>Extended Medicare Safety Net Cap:</b> \$231.15
	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion (only in association with items 31000, 31001, 31002, 31003, 31004, 31005, 31358, 31359, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or 31376)-may be claimed only once per defect (Anaes.)
45201	(See para TN.8.93 of explanatory notes to this Category) <b>Fee:</b> \$420.55 <b>Benefit:</b> 75% = \$315.45  85% = \$357.50
	Muscle, myocutaneous or skin flap, where clinically indicated to repair one surgical excision made in the removal of a malignant or non-malignant skin lesion in a patient, if the clinical relevance of the procedure is clearly annotated in the patient's record and either:
	(a) item 45201 applies and additional flap repair is required for the same defect; or
	(b) item 45201 does not apply and either:
	(i) the patient has severe pre-existing scarring, severe skin atrophy or sclerodermoid changes; or
	(ii) the repair is contiguous with a free margin (Anaes.)
45202	(See para TN.8.93, TN.8.126 of explanatory notes to this Category) <b>Fee:</b> \$420.55 <b>Benefit:</b> 75% = \$315.45  85% = \$357.50
	Single stage local flap, if indicated to repair one defect, complicated or large, excluding flap for male pattern baldness and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.) (Assist.)
45203	(See para TN.8.93 of explanatory notes to this Category) <b>Fee:</b> \$412.55 <b>Benefit:</b> 75% = \$309.45 <b>85</b> % = \$350.70 <b>Extended Medicare Safety Net Cap:</b> \$330.05
	Single stage local flap if indicated to repair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals and excluding H-flap or double advancement flap not in association with any of items 31356 to 31376 (Anaes.)
45206	(See para TN.8.93 of explanatory notes to this Category)  Fee: \$389.70  Benefit: 75% = \$292.30 85% = \$331.25  Extended Medicare Safety Net Cap: \$311.80
	H-flap or double advancement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not in association with any of items 31356 to 31376 (Anaes.)
45207	<b>Fee:</b> \$389.70 <b>Benefit:</b> 75% = \$292.30 85% = \$331.25
	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)
45209	<b>Fee:</b> \$481.35 <b>Benefit:</b> 75% = \$361.05 85% = \$409.15

T8. SUF	RGICAL OPERATION	ONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	DIRECT FLAP R	EPAIR (cross arm, abdomi	nal or similar), second stage (Anaes.)
45212	Fee: \$238.80	<b>Benefit:</b> 75% = \$179.10	85% = \$203.00
	DIRECT FLAP R	EPAIR, cross leg, first stag	e (Anaes.) (Assist.)
45215	<b>Fee:</b> \$1,030.25	<b>Benefit:</b> 75% = \$772.70	
	DIRECT FLAP R	EPAIR, cross leg, second s	tage (Anaes.) (Assist.)
45218	<b>Fee:</b> \$462.15	<b>Benefit:</b> 75% = \$346.65	
	DIRECT FLAP R		or similar), first stage (Anaes.)
45221	<b>Fee:</b> \$265.75	<b>Benefit:</b> 75% = \$199.35	85% = \$225.90
			or similar), second stage (Anaes.)
45224	<b>Fee:</b> \$119.45	<b>Benefit:</b> 75% = \$89.60	85% = \$101.55
			ormation of (Anaes.) (Assist.)
45227	Fee: \$452.55	<b>Benefit:</b> 75% = \$339.45	85% - \$384 70
10227			PEDICLE, delay of (Anaes.)
45230	<b>Fee:</b> \$226.30	<b>Benefit:</b> 75% = \$169.75	85% - \$192.40
43230			reparation of intermediate or final site and attachment to the
	site (Anaes.) (Ass		•
45233	<b>Fee:</b> \$481.35	<b>Benefit:</b> 75% = \$361.05	85% = \$409.15
	INDIRECT FLAF	OR TUBED PEDICLE, sp	preading of pedicle, as a separate procedure (Anaes.)
45236	Fee: \$377.45	<b>Benefit:</b> 75% = \$283.10	
			vision of, by incision and suture, not being a service to
	which item 45240		
45239	Fee: \$265.75	<b>Benefit:</b> 75% = \$199.35	
		ECT OR LOCAL FLAP, rev 198 or 45499 applies (Anae	vision of, by liposuction, not being a service to which item s.)
45240	Fee: \$265.75	<b>Benefit:</b> 75% = \$199.35	85% = \$225.90
		I	FREE GRAFTS
	FREE GRAFTING	G (split skin) of a granulatin	ng area, small (Anaes.)
45400	Fee: \$208.00	<b>Benefit:</b> 75% = \$156.00	85% = \$176.80
	FREE GRAFTING	G (split skin) of a granulatin	ng area, extensive (Anaes.) (Assist.)
45403	Fee: \$414.00	<b>Benefit:</b> 75% = \$310.50	85% = \$351.90
		G (split skin) to burns, included surface (Anaes.) (Assis	ading excision of burnt tissue - involving not more than 3 t.)
45406	(See para TN.8.94 o <b>Fee:</b> \$458.30	of explanatory notes to this Cat <b>Benefit:</b> 75% = \$343.75	
45409			ading excision of burnt tissue - involving 3 per cent or more
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T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	but less than 6 per cent of total body sur-	face (Anaes.) (Assist.)
	(See para TN.8.94 of explanatory notes to the <b>Fee:</b> \$611.30 <b>Benefit:</b> 75% = \$45	
	FREE GRAFTING (split skin) to burns, but less than 9 per cent of total body sur	including excision of burnt tissue - involving 6 per cent or more face (Anaes.) (Assist.)
45412	(See para TN.8.94 of explanatory notes to the <b>Fee:</b> \$840.55 <b>Benefit:</b> 75% = \$63	
	FREE GRAFTING (split skin) to burns, but less than 12 per cent of total body su	including excision of burnt tissue - involving 9 per cent or more rface (Anaes.) (Assist.)
45415	(See para TN.8.94 of explanatory notes to the <b>Fee:</b> \$916.75 <b>Benefit:</b> 75% = \$68	<del>-</del>
	FREE GRAFTING (split skin) to burns, more but less than 15 per cent of total bo	including excision of burnt tissue - involving 12 per cent or ody surface (Anaes.) (Assist.)
45418	(See para TN.8.94 of explanatory notes to the <b>Fee:</b> \$993.20 <b>Benefit:</b> 75% = \$74	
	FREE GRAFTING (split skin) to 1 defe	ct, including elective dissection, small (Anaes.)
45439	<b>Fee:</b> \$288.90 <b>Benefit:</b> 75% = \$21	6.70 85% = \$245.60
	FREE GRAFTING (split skin) to 1 defe	ct, including elective dissection, extensive (Anaes.) (Assist.)
45442	<b>Fee:</b> \$595.90 <b>Benefit:</b> 75% = \$44	6.95 85% = \$511.20
	FREE GRAFTING (split skin) as inlay g (including insertion of, and removal of n	graft to 1 defect including elective dissection using a mould nould) (Anaes.) (Assist.)
45445	<b>Fee:</b> \$565.50 <b>Benefit:</b> 75% = \$42	4.15 85% = \$480.80
		ct, including elective dissection on eyelid, nose, lip, ear, neck, g a service to which item 45442 or 45445 applies (Anaes.)
45448	<b>Fee:</b> \$382.00 <b>Benefit:</b> 75% = \$28	6.50 85% = \$324.70
	FREE GRAFTING (full thickness), to 1 (Assist.)	defect, excluding grafts for male pattern baldness (Anaes.)
45451	<b>Fee:</b> \$481.35 <b>Benefit:</b> 75% = \$36	1.05 85% = \$409.15
		including excision of burnt tissue - involving 15 percent or dy surface - one surgeon (Anaes.) (Assist.)
45460	<b>Fee:</b> \$1,273.35 <b>Benefit:</b> 75% = \$95	5.05
		including excision of burnt tissue - involving 15 percent or dy surface - conjoint surgery, principal surgeon (Anaes.)
45461	<b>Fee:</b> \$907.55 <b>Benefit:</b> 75% = \$68	0.70
		including excision of burnt tissue - involving 15 percent or dy surface - conjoint surgery, co- surgeon (Assist.)
45462	<b>Fee:</b> \$684.85 <b>Benefit:</b> 75% = \$51	3.65
45464	FREE GRAFTING (split skin) to burns,	including excision of burnt tissue - involving 20 percent or

T8. SUR	GICAL OPERATION	NS 13. PLASTIC AND RECONSTRUCTIVE SURGER
	more but less than 3	0 percent of total body surface - one surgeon (Anaes.) (Assist.)
	<b>Fee:</b> \$1,943.70	<b>Benefit:</b> 75% = \$1457.80
		(split skin) to burns, including excision of burnt tissue - involving 20 percent or 0 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)
15465	Fee: \$1,384.80	<b>Benefit:</b> 75% = \$1038.60 85% = \$1300.10
		(split skin) to burns, including excision of burnt tissue - involving 20 percent or 0 percent of total body surface - conjoint surgery, co-surgeon (Assist.)
15466	Fee: \$1,044.40	<b>Benefit:</b> 75% = \$783.30 85% = \$959.70
		(split skin) to burns, including excision of burnt tissue - involving 30 percent or 0 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)
15468	Fee: \$1,861.95	<b>Benefit:</b> 75% = \$1396.50
		(split skin) to burns, including excision of burnt tissue - involving 30 percent or 0 percent of total body surface - conjoint surgery, co-surgeon (Assist.)
15469	Fee: \$1,404.80	<b>Benefit:</b> 75% = \$1053.60 85% = \$1320.10
		(split skin) to burns, including excision of burnt tissue - involving 40 percent or 0 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)
15471	Fee: \$2,340.50	<b>Benefit:</b> 75% = \$1755.40 85% = \$2255.80
		(split skin) to burns, including excision of burnt tissue - involving 40 percent or 0 percent of total body surface - conjoint surgery, co-surgeon (Assist.)
15472	Fee: \$1,765.40	<b>Benefit:</b> 75% = \$1324.05 85% = \$1680.70
		(split skin) to burns, including excision of burnt tissue - involving 50 percent or 0 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)
15474	Fee: \$2,817.65	<b>Benefit:</b> 75% = \$2113.25 85% = \$2732.95
		(split skin) to burns, including excision of burnt tissue - involving 50 percent or 0 percent of total body surface - conjoint surgery, co-surgeon (Assist.)
15475	Fee: \$2,125.95	<b>Benefit:</b> 75% = \$1594.50 85% = \$2041.25
		(split skin) to burns, including excision of burnt tissue - involving 60 percent or 0 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)
15477	Fee: \$3,294.90	<b>Benefit:</b> 75% = \$2471.20 85% = \$3210.20
		(split skin) to burns, including excision of burnt tissue - involving 60 percent or 10 percent of total body surface - conjoint surgery, co-surgeon (Assist.)
15478	Fee: \$2,485.20	<b>Benefit:</b> 75% = \$1863.90 85% = \$2400.50
15480		(split skin) to burns, including excision of burnt tissue - involving 70 percent or 0 percent of total body surface - conjoint surgery, principal surgeon (Anaes.)

T8. SUF	RGICAL OPERATION	ONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(Assist.)			
	Fee: \$3,772.00	<b>Benefit:</b> 75% = \$2829.00	85% = \$3687.30	
			ding excision of burnt tissue - involving 70 percent or rface - conjoint surgery, co-surgeon (Assist.)	
45481	Fee: \$2,845.90	<b>Benefit:</b> 75% = \$2134.45	85% = \$2761.20	
			ding excision of burnt tissue - involving 80 percent or principal surgeon (Anaes.) (Assist.)	
45483	<b>Fee:</b> \$4,297.65	<b>Benefit:</b> 75% = \$3223.25	85% = \$4212.95	
		G (split skin) to burns, incluy surface - conjoint surgery,	ding excision of burnt tissue - involving 80 percent or co-surgeon (Assist.)	
45484	Fee: \$3,242.55	<b>Benefit:</b> 75% = \$2431.95	85% = \$3157.85	
		G (split skin) to burns, included (Anaes.) (Assist.)	ding excision of burnt tissue - upper eyelid, nose, lip, ear	
45485	Fee: \$536.15	<b>Benefit:</b> 75% = \$402.15		
		· •	ding excision of burnt tissue - forehead, cheek, anterior foot, heel or genitalia (Anaes.) (Assist.)	
45486	<b>Fee:</b> \$458.30	<b>Benefit:</b> 75% = \$343.75		
	FREE GRAFTIN (Assist.)	G (split skin) to burns, include	ding excision of burnt tissue - whole of toe (Anaes.)	
45487	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45	85% = \$350.70	
	FREE GRAFTIN hand (Anaes.) (As		ding excision of burnt tissue - the whole of 1 digit of the	
45488	Fee: \$458.30	<b>Benefit:</b> 75% = \$343.75		
	FREE GRAFTIN hand (Anaes.) (As		ding excision of burnt tissue - the whole of 2 digits of the	
45489	Fee: \$687.65	<b>Benefit:</b> 75% = \$515.75	85% = \$602.95	
	FREE GRAFTIN hand (Anaes.) (As	· •	ding excision of burnt tissue - the whole of 3 digits of the	
45490	Fee: \$916.95	<b>Benefit:</b> 75% = \$687.75		
	FREE GRAFTIN hand (Anaes.) (As		ding excision of burnt tissue - the whole of 4 digits of the	
45491	Fee: \$1,146.10	<b>Benefit:</b> 75% = \$859.60		
	FREE GRAFTIN hand (Anaes.) (As		ding excision of burnt tissue - the whole of 5 digits of the	
45492	Fee: \$1,375.25	<b>Benefit:</b> 75% = \$1031.45		
	FREE GRAFTIN (Anaes.) (Assist.)	· •	ding excision of burnt tissue - portion of digit of hand	
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T8. SUF	RGICAL OPERATION	ONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	FREE GRAFTING ears) (Anaes.) (As		ding excision of burnt tissue - whole of face (excluding	
45494	Fee: \$1,664.90	<b>Benefit:</b> 75% = \$1248.70	85% = \$1580.20	
		OTHER GRAFTS AND	MISCELLANEOUS PROCEDURES	
	FLAP, free tissue	transfer using microvascular	techniques - revision of, by open operation (Anaes.)	
45496	<b>Fee:</b> \$422.70	<b>Benefit:</b> 75% = \$317.05		
		transfer using microvascular of, by liposuction (Anaes.)	techniques, or any autogenous breast reconstruction -	
45497	Fee: \$330.15	<b>Benefit:</b> 75% = \$247.65		
		transfer using microvascular, by liposuction - first stage (	techniques, or any autogenous breast reconstruction - (Anaes.)	
45498	Fee: \$265.75	<b>Benefit:</b> 75% = \$199.35		
		transfer using microvascular, by liposuction - second stag	techniques, or any autogenous breast reconstruction - ge (Anaes.)	
45499	Fee: \$198.10	<b>Benefit:</b> 75% = \$148.60		
		AR REPAIR using microsus atremity or digit (Anaes.) (A	rgical techniques, with restoration of continuity of artery ssist.)	
45500	Fee: \$1,107.80	<b>Benefit:</b> 75% = \$830.85		
	MICROVASCUL limb or digit (Ana		ery using microsurgical techniques, for re-implantation of	
45501	<b>Fee:</b> \$1,803.10	<b>Benefit:</b> 75% = \$1352.35		
	MICROVASCUL limb or digit (Ana		n using microsurgical techniques, for re-implantation of	
45502	Fee: \$1,803.10	<b>Benefit:</b> 75% = \$1352.35		
	MICRO-ARTERI	AL OR MICRO-VENOUS	GRAFT using microsurgical techniques (Anaes.) (Assist.)	
45503	Fee: \$2,062.85	<b>Benefit:</b> 75% = \$1547.15		
		AR ANASTOMOSIS of arteting in of free flap (Anaes.)	ery using microsurgical techniques, for free transfer of (Assist.)	
45504	Fee: \$1,803.10	<b>Benefit:</b> 75% = \$1352.35		
		AR ANASTOMOSIS of vei	n using microsurgical techniques, for free transfer of (Assist.)	
45505	<b>Fee:</b> \$1,803.10	<b>Benefit:</b> 75% = \$1352.35		
			length, revision of, where undertaken in the operating specialist in the practice of his or her specialty (Anaes.)	
45506	(See para TN.8.95 of <b>Fee:</b> \$223.45	f explanatory notes to this Cate <b>Benefit:</b> 75% = \$167.60		
45512			gth, revision of, where undertaken in the operating theatre ist in the practice of his or her specialty (Anaes.)	

T8. SUR	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGE	RY
	(See para TN.8.95 of explanatory notes to this Category) <b>Fee:</b> \$300.45 <b>Benefit:</b> 75% = \$225.35  85% = \$255.40	
	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 the practice of his or her specialty (Anaes.)	in
45515	(See para TN.8.95 of explanatory notes to this Category) <b>Fee:</b> \$189.50 <b>Benefit:</b> 75% = \$142.15 85% = \$161.10	
	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedur where undertaken in the operating theatre of a hospital, or where performed by a specialist in the practice of his or her speciality (Anaes.)	e,
45518	(See para TN.8.95 of explanatory notes to this Category) <b>Fee:</b> \$229.30 <b>Benefit:</b> 75% = \$172.00 85% = \$194.95	
	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.)	
45519	<b>Fee:</b> \$435.90 <b>Benefit:</b> 75% = \$326.95	
	Reduction mammaplasty (unilateral) with surgical repositioning of nipple, in the context of breast can or developmental abnormality of the breast (Anaes.) (Assist.)	cer
45520	<b>Fee:</b> \$914.85 <b>Benefit:</b> 75% = \$686.15	
	Reduction mammaplasty (unilateral) without surgical repositioning of the nipple:	
	(a) excluding the treatment of gynaecomastia; and	
	(b) not with insertion of any prosthesis (Anaes.) (Assist.)	
45522	<b>Fee:</b> \$641.85 <b>Benefit:</b> 75% = \$481.40	
	Reduction mammaplasty (bilateral) with surgical repositioning of the nipple:	
	(a) for patients with macromastia and experiencing pain in the neck or shoulder region; and	
	(b) not with insertion of any prosthesis (Anaes.) (Assist.)	
45523	<b>Fee:</b> \$1,372.30 <b>Benefit:</b> 75% = \$1029.25	
	Mammaplasty, augmentation (unilateral) in the context of:	
	(a) breast cancer; or	
	(b) developmental abnormality of the breast, if there is a difference in breast volume, as demonstrated an appropriate volumetric measurement technique, of at least:	by
	(i) 20% in normally shaped breasts; or	
	(ii) 10% in tubular breasts or in breasts with abnormally high inframammary folds.	
	Applicable only once per occasion on which the service is provided (Anaes.) (Assist.)	
45524	(See para TN.8.96 of explanatory notes to this Category) <b>Fee:</b> \$753.50 <b>Benefit:</b> 75% = \$565.15	
45527	Breast reconstruction (unilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assi	st.)

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(See para TN.8.96 of explanatory notes <b>Fee:</b> \$753.50 <b>Benefit:</b> 75% =	
	Mammaplasty, augmentation, bilate	eral (other than a service to which item 45527 applies), if:
	(a) reconstructive surgery is indicate	ed because of:
	(i) developmental malformation	on of breast tissue (excluding hypomastia); or
	(ii) disease of or trauma to the surgery); or	breast (other than trauma resulting from previous elective cosmetic
	(iii) amastia secondary to a co	ngenital endocrine disorder; and
	(b) photographic and/or diagnostic idocumented in the patient notes (An	imaging evidence demonstrating the clinical need for this service is naes.) (Assist.)
45528	(See para TN.8.96 of explanatory notes <b>Fee:</b> \$1,130.15 <b>Benefit:</b> 75% =	
	including repair of secondary skin d	sing a latissimus dorsi or other large muscle or myocutaneous flap, lefect, if required, excluding repair of muscular aponeurotic layer, a service to which item 30165, 30168, 30171, 30172, 30176, 30177
	(H) (Anaes.) (Assist.)	
45530	(See para TN.8.97 of explanatory notes <b>Fee:</b> \$1,117.00 <b>Benefit:</b> 75% =	
		ing breast sharing technique (first stage) including breast reduction, tissue flap, split skin graft to pedicle of flap or other similar
45533	(See para TN.8.8 of explanatory notes t <b>Fee:</b> \$1,265.00 <b>Benefit:</b> 75% =	
		ing breast sharing technique (second stage) including division of h closure of donor site or other similar procedure (Anaes.) (Assist.)
45536	<b>Fee:</b> \$465.20 <b>Benefit:</b> 75% =	= \$348.90
	The state of the s	nilateral), following mastectomy, using tissue expansion - insertion adances for subsequent expansion injections (Anaes.) (Assist.)
45539	<b>Fee:</b> \$1,088.35 <b>Benefit:</b> 75% =	= \$816.30
		nilateral), following mastectomy, using tissue expansion - removal of of permanent prosthesis (Anaes.) (Assist.)
45542	Fee: \$623.20 Benefit: 75% =	= \$467.40
	NIPPLE OR AREOLA or both, reco	onstruction of, by any surgical technique (Anaes.) (Assist.)
		= \$474.40 85% = \$547.80
45545	Extended Medicare Safety Net Ca	
45546	NIPPLE OR AREOLA or both, intr mastectomy or for congenital absen	radermal colouration of, following breast reconstruction after ce of nipple

T8. SURGICAL OPERATIONS		ONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(See para TN.8.100 <b>Fee:</b> \$201.00	of explanatory notes to this C <b>Benefit:</b> 75% = \$150.75		
	BREAST PROST	HESIS, removal of, as an i	ndependent procedure (Anaes.)	
45548	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95	85% = \$239.10	
	any prosthesis. Th		of at least half of the fibrous capsule, not with insertion of the sent for histopathology and the volume removed must be tases.) (Assist.)	
45551	Fee: \$450.80	<b>Benefit:</b> 75% = \$338.10		
			nt with another prosthesis, following medical complications or symptomatic capsular contracture), if:	
	(a) either:			
		onstrated by intra-operative deformity; or	photographs post-removal that removal alone would cause	
	(ii) the originand	nal implant was inserted in	the context of breast cancer or developmental abnormality;	
		and/or diagnostic imaging e e patient notes (Anaes.) (As	evidence demonstrating the clinical need for this service is ssist.)	
45553	(See para TN.8.98 of explanatory notes to this Category) <b>Fee:</b> \$580.75 <b>Benefit:</b> 75% = \$435.60			
	(for rupture, migra	ation of prosthetic material	with another prosthesis, following medical complications or symptomatic capsular contracture), including excision of on of a new pocket, or both, if:	
	(a) either:			
		onstrated by intra-operative e deformity; or	photographs post-removal that removal alone would cause	
	(ii) the original	nal implant was inserted in	the context of breast cancer or developmental abnormality;	
	(b) the excised spe histopathology rep	-	nology and the volume removed is documented in the	
		and/or diagnostic imaging e e patient notes (Anaes.) (As	evidence demonstrating the clinical need for this service is ssist.)	
45554	(See para TN.8.98 o <b>Fee:</b> \$710.65	f explanatory notes to this Ca <b>Benefit:</b> 75% = \$533.00	tegory)	
	photographic evid	ence (including anterior, le	e context of breast cancer or developmental abnormality, if eft lateral and right lateral views) and/or diagnostic imaging this service is documented in the patient notes	
	Applicable only o	nce per occasion on which	the service is provided (Anaes.) (Assist.)	
45556	(See para TN.8.99 o <b>Fee:</b> \$778.30	of explanatory notes to this Ca <b>Benefit:</b> 75% = \$583.75	tegory)	

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Breast ptosis, correction by mastopexy of	(bilateral), if:
		including the nipple, lies inferior to the infra-mammary fold bendent, inferior part of the breast contour; and
	(b) if the patient has been pregnant—the c years, after completion of the most recent	orrection is performed not less than 1 year, or more than 7 pregnancy of the patient; and
		rior, left lateral and right lateral views), with a marker at the ating the clinical need for this service, is documented in the
	Applicable only once per lifetime (Anaes.	) (Assist.)
45558	(See para TN.8.99 of explanatory notes to this <b>Fee:</b> \$1,167.35 <b>Benefit:</b> 75% = \$875.	
		atment of alopecia of congenital or traumatic origin or due to not being a service to which another item in this Group applies
45560	Fee: \$481.25 Benefit: 75% = \$360. Extended Medicare Safety Net Cap: \$16	
	MICROVASCULAR ANASTOMOSIS o supercharging of pedicled flaps (Anaes.) (	f artery or vein using microsurgical techniques, for Assist.)
45561	<b>Fee:</b> \$1,803.10 <b>Benefit:</b> 75% = \$1352	2.35
		g raising of tissue on vascular or neurovascular pedicle, eous defect if performed, excluding flap for male pattern
45562	<b>Fee:</b> \$1,117.00 <b>Benefit:</b> 75% = \$837.	75 85% = \$1032.30
	NEUROVASCULAR ISLAND FLAP, inc performed, excluding flap for male pattern	cluding direct repair of secondary cutaneous defect if a baldness (Anaes.) (Assist.)
45563	<b>Fee:</b> \$1,117.00 <b>Benefit:</b> 75% = \$837.	75 85% = \$1032.30
	deformity, surgery or trauma, involving ar and including raising of tissue on a vascul transfer of tissue, insetting of tissue at reci performed, other than a service associated	ery for the repair of major tissue defect due to congenital nastomoses of up to 2 vessels using microvascular techniques ar or neurovascular pedicle, preparation of recipient vessels, pient site and direct repair of secondary cutaneous defect if with a service to which item 30165, 30168, 30171, 30172, 14, 45505 or 45562 applies-conjoint surgery, principal
45564	(See para TN.8.8 of explanatory notes to this C <b>Fee:</b> \$2,587.05 <b>Benefit:</b> 75% = \$1940	
45565	Free transfer of tissue reconstructive surged deformity, surgery or trauma, involving an and including raising of tissue on a vascul transfer of tissue, insetting of tissue at reciperformed, other than a service associated	ery for the repair of major tissue defect due to congenital nastomoses of up to 2 vessels using microvascular techniques ar or neurovascular pedicle, preparation of recipient vessels, pient site and direct repair of secondary cutaneous defect if with a service to which item 30165, 30168, 30171, 30172, 14, 45505 or 45562 applies-conjoint surgery, conjoint specialist
75505		

T8. SUF	GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	(See para TN.8.8 of <b>Fee:</b> \$1,940.35	explanatory notes to this Category) <b>Benefit:</b> 75% = \$1455.30		
		ION not being a service to which item 45539 or 45542 applies - insertion of tissue all attendances for subsequent expansion injections (Anaes.) (Assist.)		
45566	Fee: \$1,088.35	<b>Benefit:</b> 75% = \$816.30		
	TISSUE EXPANI	DER, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)		
45568	Fee: \$450.80	<b>Benefit:</b> 75% = \$338.10		
		BDOMEN WITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, ociated with items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)		
45569	Fee: \$688.45	<b>Benefit:</b> 75% = \$516.35		
	CLOSURE OF AF 45569 (Anaes.) (A	BDOMEN, repair of musculoaponeurotic layer, being a service associated with item ssist.)		
45570	Fee: \$929.60	<b>Benefit:</b> 75% = \$697.20 85% = \$844.90		
	service to which a	VE TISSUE EXPANSION performed during an operation when combined with a nother item in Group T8 applies including expansion injections and excluding pattern baldness (Anaes.)		
45572	Fee: \$296.35	<b>Benefit:</b> 75% = \$222.30 85% = \$251.90		
	FACIAL NERVE	PARALYSIS, free fascia graft for (Anaes.) (Assist.)		
45575	<b>Fee:</b> \$731.70	<b>Benefit:</b> 75% = \$548.80 85% = \$647.00		
	FACIAL NERVE	PARALYSIS, muscle transfer for (Anaes.) (Assist.)		
45578	Fee: \$847.40	<b>Benefit:</b> 75% = \$635.55		
	FACIAL NERVE	PALSY, excision of tissue for (Anaes.)		
45581	Fee: \$281.25	<b>Benefit:</b> 75% = \$210.95 85% = \$239.10		
	traumatic pseudoli	on assisted lipolysis) to one regional area (one limb or trunk), for treatment of post poma, if photographic and/or diagnostic imaging evidence demonstrating the clinical re is documented in the patient notes (Anaes.)		
45584	(See para TN.8.8, TI <b>Fee:</b> \$641.85	N.8.101 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$481.40		
		on assisted lipolysis) to one regional area (one limb or trunk), other than a service ervice to which item 31525 applies, if:		
	(a) the liposuction	is for:		
	(i) the treatm	ent of Barraquer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or		
	(ii) the reduction of a buffalo hump that is secondary to an endocrine disorder or pharmacological treatment of a medical condition; and			
		nd/or diagnostic imaging evidence demonstrating the clinical need for this service is patient notes (Anaes.)		
45585	(See para TN.8.8, Th <b>Fee:</b> \$641.85	N.8.101 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$481.40		

T8. SUF	RGICAL OPERATION	ONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Meloplasty for con	rection of facial asymmetr	y if:
		is secondary to trauma (in (such as facial nerve palsy	cluding previous surgery), a congenital condition or a
	(b) the meloplasty	is limited to one side of th	e face (Anaes.) (Assist.)
45587	(See para TN.8.102 <b>Fee:</b> \$905.10	of explanatory notes to this C <b>Benefit:</b> 75% = \$678.85	ategory)
	Meloplasty (exclu-	ding browlifts and chinlift	platysmaplasties), bilateral, if:
			l impairment due to a congenital condition, disease ner than trauma resulting from previous elective cosmetic
		nd/or diagnostic imaging e patient notes (Anaes.) (As	evidence demonstrating the clinical need for this service is ssist.)
45588	(See para TN.8.102 <b>Fee:</b> \$1,357.80	of explanatory notes to this C <b>Benefit:</b> 75% = \$1018.35	
	·		ll or floor, with or without foreign implant (Anaes.) (Assist.)
45590	<b>Fee:</b> \$491.00	<b>Benefit:</b> 75% = \$368.25	
		ΓY, bone or cartilage graft contents (Anaes.) (Assist.)	to orbital wall or floor including reduction of prolapsed or
45593	Fee: \$576.75	<b>Benefit:</b> 75% = \$432.60	
	MAXILLA, total 1	resection of (Anaes.) (Assi	st.)
45596	Fee: \$914.85	<b>Benefit:</b> 75% = \$686.15	
	MAXILLA, total 1	resection of both maxillae	(Anaes.) (Assist.)
45597	Fee: \$1,224.70	<b>Benefit:</b> 75% = \$918.55	
	MANDIBLE, tota	l resection of both sides, in	acluding condylectomies where performed (Anaes.) (Assist.)
45599	Fee: \$951.55	<b>Benefit:</b> 75% = \$713.70	85% = \$866.85
	MANDIBLE, incl	uding lower border, OR M	AXILLA, sub-total resection of (Anaes.) (Assist.)
45602	Fee: \$710.65	<b>Benefit:</b> 75% = \$533.00	
	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.)		ection of, for tumours or cysts (Anaes.) (Assist.)
45605	<b>Fee:</b> \$597.00	<b>Benefit:</b> 75% = \$447.75	
	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.)		
45608	Fee: \$840.55	<b>Benefit:</b> 75% = \$630.45	
	MANDIBLE, con	dylectomy (Anaes.) (Assis	t.)
45611	<b>Fee:</b> \$481.35	<b>Benefit:</b> 75% = \$361.05	
15614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.)		TRUCTION OF other than by direct suture only (Anaes.)
45614			

T8. SUI	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	Fee: \$597.00 Benefit: 75% Extended Medicare Safety Net C	= \$447.75 85% = \$512.30 <b>Cap:</b> \$477.60		
	Upper eyelid, reduction of, if:			
	(a) the reduction is for any of the f	following:		
	(i) skin redundancy that causes a visual field defect (confirmed by an optometrist or ophthalmologist) or intertriginous inflammation of the eyelid;			
	(ii) herniation of orbital fat in	n exophthalmos;		
	(iii) facial nerve palsy;			
	(iv) post-traumatic scarring;			
	(v) the restoration of symmet mentioned in subparagraphs	try of contralateral upper eyelid in respect of one of the conditions (i) to (iv); and		
	(b) photographic and/or diagnostic documented in the patient notes (A	imaging evidence demonstrating the clinical need for this service is anaes.)		
45617	(See para TN.8.103 of explanatory not Fee: \$238.80 Benefit: 75% Extended Medicare Safety Net C	= \$179.10 85% = \$203.00		
	Lower eyelid, reduction of, if:	-		
	(a) the reduction is for:			
	(i) herniation of orbital fat in	exophthalmos, facial nerve palsy or post-traumatic scarring; or		
	(ii) the restoration of symmetric conditions; and	try of the contralateral lower eyelid in respect of one of these		
	(b) photographic and/or diagnostic documented in the patient notes (A	imaging evidence demonstrating the clinical need for this service is anaes.)		
45620	(See para TN.8.103 of explanatory not Fee: \$331.25 Benefit: 75% Extended Medicare Safety Net C	= \$248.45   85% = \$281.60		
	Ptosis of upper eyelid (unilateral),	•		
	(a) sutured elevation of the tarsal plate on the eyelid retractors (Muller's or levator muscle aponeurosis); or			
	(b) sutured suspension to the brow	/frontalis muscle;		
	Not applicable to a service for repa	air of mechanical ptosis to which item 45617 applies (Anaes.) (Assist.)		
45623	Fee: \$734.60 Benefit: 75% = \$550.95 85% = \$649.90 Extended Medicare Safety Net Cap: \$587.70			
	Ptosis of upper eyelid, correction of			
	(a) sutured elevation of the tarsal paponeurosis); or	plate on the eyelid retractors (Muller's or levator muscle or levator		
45624				

T8. SUR	GICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY			
	(b) sutured suspension to the brow/frontalis muscle;			
	if a previous ptosis surgery has been performed on that side (Anaes.) (Assist.)			
	<b>Fee:</b> \$952.40 <b>Benefit:</b> 75% = \$714.30 85% = \$867.70 <b>Extended Medicare Safety Net Cap:</b> \$761.95			
	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.)			
45625	<b>Fee:</b> \$190.55 <b>Benefit:</b> 75% = \$142.95			
	Ectropion or entropion, not caused by trachoma, correction of (unilateral) (Anaes.)			
45626	<b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45 85% = \$281.60			
	Ectropion or entropion, caused by trachoma, correction of (unilateral) (Anaes.)			
45627 S	<b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45 85% = \$281.60			
	SYMBLEPHARON, grafting for (Anaes.) (Assist.)			
45629	<b>Fee:</b> \$481.35 <b>Benefit:</b> 75% = \$361.05 85% = \$409.15			
	Rhinoplasty, partial, involving correction of lateral or alar cartilages, if:			
	(a) the indication for surgery is:			
	(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or			
	(ii) significant acquired, congenital or developmental deformity; and			
	(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)			
45632	(See para TN.8.104 of explanatory notes to this Category) <b>Fee:</b> \$520.15 <b>Benefit:</b> 75% = \$390.15 85% = \$442.15 <b>Extended Medicare Safety Net Cap:</b> \$416.15			
	Rhinoplasty, partial, involving correction of bony vault only, if:			
	(a) the indication for surgery is:			
	(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or			
	(ii) significant acquired, congenital or developmental deformity; and			
	(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)			
45.625	(See para TN.8.104 of explanatory notes to this Category) <b>Fee:</b> \$597.00 <b>Benefit:</b> 75% = \$447.75 85% = \$512.30			
45635	Extended Medicare Safety Net Cap: \$477.60  Rhinoplasty, total, including correction of all bony and cartilaginous elements of the external nose, with or without autogenous cartilage or bone graft from a local site (nasal), if:			
	(a) the indication for surgery is:			
45641	(i) airway obstruction and the patient has a self-reported NOSE Scale score of greater than 45; or			

T8. SUR	GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE	SURGERY
	(ii) significan	nt acquired, congenital or developmental deformity; and	
		and/or NOSE Scale evidence demonstrating the clinical need for this service patient notes (Anaes.)	e is
	(See para TN.8.104 <b>Fee:</b> \$1,083.05	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$812.30	
		, including correction of all bony and cartilaginous elements of the external ous bone or cartilage graft obtained from distant donor site, including obtain	
	(a) the indication f	for surgery is:	
	(i) airway ob	ostruction and the patient has a self-reported NOSE Scale score of greater th	nan 45; or
	(ii) significat	nt acquired, congenital or developmental deformity; and	
		and/or NOSE Scale evidence demonstrating the clinical need for this service patient notes (Anaes.) (Assist.)	e is
45644	(See para TN.8.104 <b>Fee:</b> \$1,299.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$974.95	
	CHOANAL ATRI	ESIA, repair of by puncture and dilatation (Anaes.)	
45645	Fee: \$227.20	<b>Benefit:</b> 75% = \$170.40	
	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.)		
45646	<b>Fee:</b> \$914.85 <b>Benefit:</b> 75% = \$686.15 85% = \$830.15		
	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.)		service to
45647	(See para TN.8.105 <b>Fee:</b> \$1,299.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$974.95	
	Rhinoplasty, revision of, if:		
	(a) the indication f	for surgery is:	
	(i) airway ob	ostruction and the patient has a self-reported NOSE Scale score of greater th	nan 45; or
	(ii) significan	nt acquired, congenital or developmental deformity; and	
	(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)		e is
45650	(See para TN.8.104 <b>Fee:</b> \$150.15	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$112.65 85% = \$127.65	
	Rhinophyma of a (Anaes.)	moderate or severe degree, carbon dioxide laser or erbium laser excision - a	ablation of
45652	Fee: \$362.05 Extended Medica	<b>Benefit:</b> 75% = \$271.55 85% = \$307.75 are <b>Safety Net Cap:</b> \$289.65	
	RHINOPHYMA,	shaving of (Anaes.)	
45653	Fee: \$362.05	<b>Benefit:</b> 75% = \$271.55 85% = \$307.75	

T8. SUF	RGICAL OPERATIONS 1:	3. PLASTIC AND RECONSTRUCTIVE SURGERY	
	COMPOSITE GRAFT (Chondrocutaneous or ch	ondromucosal) to nose, ear or eyelid (Anaes.) (Assist.)	
45656	<b>Fee:</b> \$510.30 <b>Benefit:</b> 75% = \$382.75 85	% = \$433.80	
	Correction of a congenital deformity of the ear if	:	
	(a) the patient is less than 18 years of age; and		
	(b) the deformity is characterised by an absence concha; and	of the antihelical fold and/or large scapha and/or large	
	(c) photographic evidence demonstrating the clinical need for this service is documented in the notes (Anaes.) (Assist.)		
45659	<b>Fee:</b> \$529.60 <b>Benefit:</b> 75% = \$397.20		
	grafts to form a framework, including the harvest	NSTRUCTION OF, using multiple costal cartilage ing and sculpturing of the cartilage and its insertion, for ss of entire or substantial portion of pinna (first stage) - her specialty (Anaes.) (Assist.)	
45660	<b>Fee:</b> \$2,924.80 <b>Benefit:</b> 75% = \$2193.60		
	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 fasc 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.)		
45661	<b>Fee:</b> \$1,299.90 <b>Benefit:</b> 75% = \$974.95		
	CONGENITAL ATRESIA, reconstruction of ext	ernal auditory canal (Anaes.) (Assist.)	
45662	<b>Fee:</b> \$712.50 <b>Benefit:</b> 75% = \$534.40		
	LIP, EYELID OR EAR, FULL THICKNESS WI (Anaes.)	EDGE EXCISION OF, with repair by direct sutures	
45665	<b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45 85	% = \$281.60	
	VERMILIONECTOMY, by surgical excision (Anaes.)		
45668	<b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45 85°	% = \$281.60	
	Vermilionectomy for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser excision - ablation (Anaes.)		
45669	(See para TN.8.106 of explanatory notes to this Categor <b>Fee:</b> \$331.25 <b>Benefit:</b> 75% = \$248.45 85	- <del>-</del> -	
	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)		
45671	<b>Fee:</b> \$847.40 <b>Benefit:</b> 75% = \$635.55 85	% = \$762.70	
	LIP OR EYELID RECONSTRUCTION using fu (Anaes.)	ıll thickness flap (Abbe or similar), second stage	
45674	<b>Fee:</b> \$246.45 <b>Benefit:</b> 75% = \$184.85 85	% = \$209.50	
	MACROCHEILIA or macroglossia, operation fo		
45675	<b>Fee:</b> \$491.00 <b>Benefit:</b> 75% = \$368.25		

GICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
MACROSTOMIA	A, operation for (Anaes.) (Assist.)	
<b>Fee:</b> \$584.50	<b>Benefit:</b> 75% = \$438.40	
CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)		
Fee: \$550.00	<b>Benefit:</b> 75% = \$412.50	
CLEFT LIP, unila	ateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	
<b>Fee:</b> \$687.65	<b>Benefit:</b> 75% = \$515.75	
CLEFT LIP, bilat	eral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)	
<b>Fee:</b> \$763.90	<b>Benefit:</b> 75% = \$572.95	
CLEFT LIP, bilat	eral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)	
<b>Fee:</b> \$901.70	<b>Benefit:</b> 75% = \$676.30	
CLEFT LIP, lip a	dhesion procedure, unilateral or bilateral (Anaes.) (Assist.)	
Fee: \$265 95	<b>Benefit:</b> 75% = \$199.50	
CLEFT LIP, parti	ial revision, including minor flap revision alignment and adjustment, including revision deformity if performed (Anaes.)	
Fee: \$305.55	<b>Benefit:</b> 75% = \$229.20 85% = \$259.75	
	revision, including major flap revision, muscle reconstruction and revision of major (Anaes.) (Assist.)	
<b>Fee:</b> \$496.55	<b>Benefit:</b> 75% = \$372.45	
CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.)		
<b>Fee:</b> \$466.10	<b>Benefit:</b> 75% = \$349.60	
CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.)		
Fee: \$840.55	<b>Benefit:</b> 75% = \$630.45	
CLEFT LIP REC	ONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)	
Fee: \$305.55	<b>Benefit:</b> 75% = \$229.20 85% = \$259.75	
CLEFT PALATE	c, primary repair (Anaes.) (Assist.)	
<b>Fee:</b> \$794.45	<b>Benefit:</b> 75% = \$595.85	
CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.)		
<b>Fee:</b> \$496.55	<b>Benefit:</b> 75% = \$372.45	
CLEFT PALATE	z, secondary repair, lengthening procedure (Anaes.) (Assist.)	
<b>Fee:</b> \$565.50	<b>Benefit:</b> 75% = \$424.15	
	STULA, plastic closure of, including services to which item 45200, 45203 or 45239	
<b>Fee:</b> \$794.45	<b>Benefit:</b> 75% = \$595.85	
	MACROSTOMIA Fee: \$584.50  CLEFT LIP, unils Fee: \$550.00  CLEFT LIP, unils Fee: \$687.65  CLEFT LIP, bilat Fee: \$763.90  CLEFT LIP, bilat Fee: \$901.70  CLEFT LIP, lip a Fee: \$265.95  CLEFT LIP, partion of minor whistle of minor whistle of minor whistle of minor whistle of minor whistle deformity Fee: \$496.55  CLEFT LIP, print Fee: \$496.55  CLEFT LIP REC (Assist.)  Fee: \$305.55  CLEFT LIP REC (Assist.)  Fee: \$466.10  CLEFT LIP REC (Assist.)  Fee: \$496.55  CLEFT PALATE Fee: \$794.45  CLEFT PALATE Fee: \$496.55	

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	VELO-PHARYNGEAL INCOMPE	TENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.)	
45716	<b>Fee:</b> \$794.45 <b>Benefit:</b> 75% =	\$595.85	
		eral osteotomy or osteectomy of, including transposition of nerves m the same site and excluding services to which item 47933or	
45720	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$982.25 <b>Benefit:</b> 75% =	to this Category) \$736.70 85% = \$897.55	
	and vessels and bone grafts taken fro	eral osteotomy or osteectomy of, including transposition of nerves m the same site and stabilisation with fixation by wires, screws, and excluding services to which item 47933 or 47936 apply (Anaes.)	
45723	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,107.80 <b>Benefit:</b> 75% =		
		ral osteotomy or osteectomy of, including transposition of nerves m the same site, and excluding services to which item 47933 or	
45726	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,251.75 <b>Benefit:</b> 75% =		
	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of no and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screplates or pins, or any combination, and excluding services to which item 47933 or 47936 apply ((Assist.)		
45729	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,405.80 <b>Benefit:</b> 75% =		
	1 jaw, including transposition of nerv	mies or osteectomies of, involving 3 or more such procedures on the ves and vessels and bone grafts taken from the same site, and 033 or 47936 apply (Anaes.) (Assist.)	
45731	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,425.15 <b>Benefit:</b> 75% =		
	the 1 jaw, including transposition of	omies or osteectomies of, involving 3 or more such procedures on nerves and vessels and bone grafts taken from the same site and crews, plates or pins, or any combination, and excluding services to naes.) (Assist.)	
45732	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,604.45 <b>Benefit:</b> 75% =		
	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.)		
45735	(See para TN.8.107 of explanatory notes <b>Fee:</b> \$1,636.85 <b>Benefit:</b> 75% =		
45738	jaw, including transposition of nerve	otomies or osteectomies of, involving 2 such procedures of each s and vessels and bone grafts taken from the same site and crews, plates or pins, or any combination, and excluding services to naes.) (Assist.)	

T8. SUR	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	(See para TN.8.107 of explanatory note <b>Fee:</b> \$1,841.40 <b>Benefit:</b> 75%		
	such procedures of 1 jaw and 2 such	implex bilateral osteotomies or osteectomies of, involving 3 or more in procedures of the other jaw, including genioplasty when performed sels and bone grafts taken from the same site, and excluding services by (Anaes.) (Assist.)	
45741	(See para TN.8.107 of explanatory note <b>Fee:</b> \$1,800.65 <b>Benefit:</b> 75%		
	such procedures of 1 jaw and 2 such and transposition of nerves and ves	mplex bilateral osteotomies or osteectomies of, involving 3 or more h procedures of the other jaw, including genioplasty when performed sels and bone grafts taken from the same site and stabilisation with pins, or any combination, and excluding services to which item sist.)	
45744	(See para TN.8.107 of explanatory note <b>Fee:</b> \$2,024.60 <b>Benefit:</b> 75%		
	such procedures of each jaw, include	mplex bilateral osteotomies or osteectomies of, involving 3 or more ling genioplasty (when performed) and transposition of nerves and the same site, and excluding services to which item 47933 or 47936	
45747	(See para TN.8.107 of explanatory note <b>Fee:</b> \$1,964.50 <b>Benefit:</b> 75%	es to this Category) = \$1473.40	
	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.)		
45752	(See para TN.8.107 of explanatory note <b>Fee:</b> \$2,200.40 <b>Benefit:</b> 75% :		
	III(Malar-Maxillary), Le Fort III in	e Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort volving 3 or more osteotomies of the midface including transposition its taken from the same site (Anaes.) (Assist.)	
45753	Fee: \$2,213.45 Benefit: 75%	= \$1660.10 85% = \$2128.75	
	(Malar-Maxillary), Le Fort III invo	e Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III lving 3 or more osteotomies of the midface including transposition of taken from the same site and stabilisation with fixation by wires, ination (Anaes.) (Assist.)	
45754	Fee: \$2,653.40 <b>Benefit:</b> 75% = \$1990.05		
	TEMPOROMANDIBULAR PART	TIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)	
45755	Fee: \$373.65 Benefit: 75%	= \$280.25 85% = \$317.65	
	TEMPORO-MANDIBULAR JOIN	T, arthroplasty (Anaes.) (Assist.)	
45758	Fee: \$668.60 Benefit: 75%	= \$501.45	
	<u> </u>		

T8. SUF	RGICAL OPERATION	NS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	(See para TN.8.108 <b>Fee:</b> \$760.65	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$570.50		
	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.)			
45767	<b>Fee:</b> \$2,551.85	<b>Benefit:</b> 75% = \$1913.90 85% = \$2467.15		
	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.)			
45770	<b>Fee:</b> \$1,954.70	<b>Benefit:</b> 75% = \$1466.05		
	TREACHER COI grafts (Anaes.) (A	LINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone sist.)		
45773	Fee: \$1,781.45	<b>Benefit:</b> 75% = \$1336.10 85% = \$1696.75		
	ORBITAL DYST intracranial (Anae	OPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, .) (Assist.)		
45776	Fee: \$1,781.45	<b>Benefit:</b> 75% = \$1336.10		
	ORBITAL DYST extracranial (Anae	OPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, s.) (Assist.)		
45779	Fee: \$1,309.80	<b>Benefit:</b> 75% = \$982.35		
	FRONTOORBITA	L ADVANCEMENT, UNILATERAL (Anaes.) (Assist.)		
45782	<b>Fee:</b> \$1,001.45	<b>Benefit:</b> 75% = \$751.10 85% = \$916.75		
	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.)			
45785	<b>Fee:</b> \$1,694.80	<b>Benefit:</b> 75% = \$1271.10		
		A, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, que) (Anaes.) (Assist.)		
45788	Fee: \$1,675.50	<b>Benefit:</b> 75% = \$1256.65		
		LE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, esting of graft material (Anaes.) (Assist.)		
45791	<b>Fee:</b> \$905.10	<b>Benefit:</b> 75% = \$678.85		
	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture, not for implantable bone conduction hearing system device (Anaes.)			
45794	<b>Fee:</b> \$511.90	<b>Benefit:</b> 75% = \$383.95 85% = \$435.15		
	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment, not for implantable bone conduction hearing system device (Anaes.)			
45797	<b>Fee:</b> \$189.50	<b>Benefit:</b> 75% = \$142.15 85% = \$161.10		
	ORAL AND MAXILLOFACIAL SURGERY			
	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain ma diagnostic purposes and not being a service associated with an operative procedure on the same (Anaes.)			
45799	<b>Fee:</b> \$29.90 <b>Benefit:</b> 75% = \$22.45 85% = \$25.45			
45801	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an			

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
		al region, up to 3 cm in diameter, removal from cutaneous or membrane, where the removal is by surgical excision and suture, 303 applies (Anaes.)
	(See para TN.8.109 of explanatory notes <b>Fee:</b> \$128.95 <b>Benefit:</b> 75% =	to this Category) \$96.75 85% = \$109.65
	an operation), in the oral and maxillo subcutaneous tissue or from mucous	SCARS, (other than a scar removed during the surgical approach at facial region, up to 3 cm in diameter, removal from cutaneous or membrane, where the removal is by surgical excision and suture, ore than 3 but not more than 10 lesions (Anaes.) (Assist.)
45803	(See para TN.8.109 of explanatory notes <b>Fee:</b> \$331.25 <b>Benefit:</b> 75% =	to this Category) \$248.45 85% = \$281.60
		AR, (other than a scar removed during the surgical approach at an ial region, more than 3 cm in diameter, removal from cutaneous or membrane (Anaes.)
45805	(See para TN.8.109 of explanatory notes <b>Fee:</b> \$175.25 <b>Benefit:</b> 75% =	to this Category) \$131.45 85% = \$149.00
	established by radiological examinati lining and tooth structure or where a ULCER OR SCAR (other than a scar	associated with a tooth or tooth fragment unless it has been from that there is a minimum of 5mm separation between the cyst tumour or cyst has been proven by positive histopathology), removed during the surgical approach at an operation), in the oral not being a service to which another item in this Subgroup applies, p tissue (Anaes.)
45807	(See para TN.8.109 of explanatory notes <b>Fee:</b> \$250.45 <b>Benefit:</b> 75% =	to this Category) \$187.85
	been established by radiological exar cyst lining and tooth structure or whe	han a cyst associated with a tooth or tooth fragment unless it has mination that there is a minimum of 5mm separation between the ere a tumour or cyst has been proven by positive histopathology), in noval of, requiring wide excision, not being a service to which is (Anaes.) (Assist.)
45809	(See para TN.8.109 of explanatory notes <b>Fee:</b> \$377.45 <b>Benefit:</b> 75% =	to this Category) \$283.10 85% = \$320.85
	TUMOUR, in the oral and maxillofac	cial region, removal of, from soft tissue (including muscle, fascia ision of, without skin or mucosal graft (Anaes.) (Assist.)
45811	(See para TN.8.109 of explanatory notes <b>Fee:</b> \$510.30 <b>Benefit:</b> 75% =	to this Category) \$382.75
		cial region, removal of, from soft tissue (including muscle, fascia ision of, with skin or mucosal graft (Anaes.) (Assist.)
45813	(See para TN.8.109 of explanatory notes <b>Fee:</b> \$597.00 <b>Benefit:</b> 75% =	to this Category) \$447.75 85% = \$512.30
	OPERATION ON MANDIBLE OR - 1 bone or in combination with adjoint	MAXILLA (other than alveolar margins) for chronic osteomyelitis ining bones (Anaes.) (Assist.)
45815		\$271.55 85% = \$307.75
	OPERATION on SKULL for OSTE	
45817	<b>Fee:</b> \$471.95 <b>Benefit:</b> 75% =	\$354.00 85% = \$401.20

T8. SURGICAL OPERATIONS			13. PLASTIC AND RECONSTRUCTIVE SURGERY	
		N ANY COMBINATION OF ADJOI AL REGION, being bones referred to	INING BONES IN THE ORAL AND to in item 45817 (Anaes.) (Assist.)	
45819	Fee: \$596.95	<b>Benefit:</b> 75% = \$447.75 85% = \$	512.25	
	BONE GROWT (Anaes.) (Assist.		ND MAXILLOFACIAL REGION, insertion of	
45821	Fee: \$386.90	<b>Benefit:</b> 75% = \$290.20 85% = \$	328.90	
			tal fixation purposes to the maxilla or mandible, taken in the operating theatre of a hospital	
45823	Fee: \$110.65	<b>Benefit:</b> 75% = \$83.00		
	MANDIBULAR	OR PALATAL EXOSTOSIS, excisi	on of (Anaes.) (Assist.)	
45825	Fee: \$343.75	<b>Benefit:</b> 75% = \$257.85 85% = \$	292.20	
	MYLOHYOID F	RIDGE, reduction of (Anaes.) (Assist	.)	
45827	Fee: \$328.55	<b>Benefit:</b> 75% = \$246.45 85% = \$	279.30	
	MAXILLARY T	UBEROSITY, reduction of (Anaes.)		
45829	Fee: \$250.65	<b>Benefit:</b> 75% = \$188.00 85% = \$	213.10	
	PAPILLARY H	YPERPLASIA OF THE PALATE, re	moval of - less than 5 lesions (Anaes.) (Assist.)	
45831	Fee: \$328.55	<b>Benefit:</b> 75% = \$246.45 85% = \$	279.30	
	PAPILLARY H	YPERPLASIA OF THE PALATE, re	moval of - 5 to 20 lesions (Anaes.) (Assist.)	
45833	Fee: \$412.55	<b>Benefit:</b> 75% = \$309.45 85% = \$	350.70	
	PAPILLARY H	YPERPLASIA OF THE PALATE, re	moval of - more than 20 lesions (Anaes.) (Assist.)	
45835	<b>Fee:</b> \$511.90	<b>Benefit:</b> 75% = \$383.95 85% = \$	435.15	
	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)			
45837	Fee: \$595.90	<b>Benefit:</b> 75% = \$446.95 85% = \$	511.20	
		UTH LOWERING (Obwegeser or singraft when performed - unilateral (An	milar procedure), including excision of muscle and aes.) (Assist.)	
45839	Fee: \$595.90	<b>Benefit:</b> 75% = \$446.95 85% = \$	511.20	
	ALVEOLAR RI	DGE AUGMENTATION with bone	or alloplast or both - unilateral (Anaes.) (Assist.)	
45841	Fee: \$481.25	<b>Benefit:</b> 75% = \$360.95 85% = \$	409.10	
		DGE AUGMENTATION - unilateral dibular alveolar ridge region for (An	, insertion of tissue expanding device into aes.) (Assist.)	
45843	Fee: \$295.15	<b>Benefit:</b> 75% = \$221.40 85% = \$	250.90	
	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)			
45845	<b>Fee:</b> \$511.90	<b>Benefit:</b> 75% = \$383.95 85% = \$	435.15	
		<u> </u>		

T8. SURGICAL OPERATIONS			13. PLASTIC AND RECONSTRUCTIVE SURGERY	
			ation of transmucosal abutment to fixtures placed andible for benign or malignant tumours (Anaes.)	
45847	Fee: \$189.50	<b>Benefit:</b> 75% = \$142.15	85% = \$161.10	
		INUS, BONE GRAFT to floo ure), (unilateral) (Anaes.) (As	or of maxillary sinus following elevation of mucosal lining ssist.)	
45849	Fee: \$590.20	<b>Benefit:</b> 75% = \$442.65	85% = \$505.50	
	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital, not being a service associated with a service to which another item in this Subgroup applies (Anaes.)			
45851	Fee: \$145.25	<b>Benefit:</b> 75% = \$108.95		
		YLE and ASCENDING RAN ing of graft material (Anaes.)	MUS in hemifacial microsomia, construction of, not (Assist.)	
45853	Fee: \$905.10	<b>Benefit:</b> 75% = \$678.85	85% = \$820.40	
			opy of, with or without biopsy, not being a service are of that joint (Anaes.) (Assist.)	
45855	Fee: \$415.25	<b>Benefit:</b> 75% = \$311.45	85% = \$353.00	
	of adhesions - 1 of		opy of, removal of loose bodies, debridement, or treatment t joint, not being a service associated with any other alar joint (Anaes.) (Assist.)	
45857	Fee: \$664.25	<b>Benefit:</b> 75% = \$498.20	85% = \$579.55	
		DIBULAR JOINT, arthroton (Anaes.) (Assist.)	ny of, not being a service to which another item in this	
45859	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15	85% = \$284.65	
	TEMPOROMAN techniques (Anae		gical exploration of, with or without microsurgical	
45861	Fee: \$886.25	<b>Benefit:</b> 75% = \$664.70	85% = \$801.55	
		DIBULAR JOINT, open surnicrosurgical techniques (Ana	gical exploration of, with condylectomy or condylotomy, es.) (Assist.)	
45863	Fee: \$982.45	<b>Benefit:</b> 75% = \$736.85	85% = \$897.75	
	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.)			
45865	Fee: \$295.15	<b>Benefit:</b> 75% = \$221.40	85% = \$250.90	
	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)			
45867	<b>Fee:</b> \$317.30	<b>Benefit:</b> 75% = \$238.00	85% = \$269.75	
	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.)			
45869	<b>Fee:</b> \$1,207.20 <b>Benefit:</b> 75% = \$905.40 85% = \$1122.50		85% = \$1122.50	
45871		IDIBULAR JOINT, open sur	gical exploration of, with meniscus, capsular and condylar	

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	head surgery, with or without microsurg	ical techniques (Anaes.) (Assist.)
	<b>Fee:</b> \$1,359.85 <b>Benefit:</b> 75% = \$10	19.90 85% = \$1275.15
		rgery of, involving procedures to which items 45863, 45867, ng the use of tissue flaps, or cartilage graft, or allograft implants, s (Anaes.) (Assist.)
45873	<b>Fee:</b> \$1,528.10 <b>Benefit:</b> 75% = \$11	46.10 85% = \$1443.40
		abilisation of, involving 1 or more of: repair of capsule, repair of service to which another item in this Subgroup applies (Anaes.)
45875	<b>Fee:</b> \$478.25 <b>Benefit:</b> 75% = \$35	8.70 85% = \$406.55
	TEMPOROMANDIBULAR JOINT, art to which another item in this Subgroup a	hrodesis of, with synovectomy if performed, not being a service applies (Anaes.) (Assist.)
45877	<b>Fee:</b> \$478.25 <b>Benefit:</b> 75% = \$35	8.70 85% = \$406.55
	TEMPOROMANDIBULAR JOINT OR treatment of fractures (Anaes.) (Assist.)	JOINTS, application of external fixator to, other than for
45879	<b>Fee:</b> \$317.30 <b>Benefit:</b> 75% = \$23	8.00 85% = \$269.75
	The treatment of a premalignant lesion or carbon dioxide laser.	of the oral mucosa by a treatment using cryotherapy, diathermy
45882	<b>Fee:</b> \$43.70 <b>Benefit:</b> 75% = \$32	.80 85% = \$37.15
	Facial, mandibular or lingual artery or vitem 41707 applies (Anaes.) (Assist.)	ein or artery and vein, ligation of, not being a service to which
45885	<b>Fee:</b> \$450.80 <b>Benefit:</b> 75% = \$33	8.10 85% = \$383.20
	FOREIGN BODY, in the oral and maxil techniques (Anaes.) (Assist.)	lofacial region, deep, removal of using interventional imaging
45888	<b>Fee:</b> \$420.15 <b>Benefit:</b> 75% = \$31	5.15 85% = \$357.15
	SINGLE-STAGE LOCAL FLAP where (Assist.)	indicated, repair to 1 defect, using temporalis muscle (Anaes.)
45891	<b>Fee:</b> \$612.10 <b>Benefit:</b> 75% = \$45	9.10 85% = \$527.40
	FREE GRAFTING, in the oral and maxi (Anaes.)	illofacial region, (mucosa or split skin) of a granulating area
45894	<b>Fee:</b> \$208.00 <b>Benefit:</b> 75% = \$15	6.00 85% = \$176.80
	ALVEOLAR CLEFT (congenital) unila nasal fistulae and ridge augmentation (A	teral, grafting of, including plastic closure of associated oro- anaes.) (Assist.)
45897	<b>Fee:</b> \$1,086.20 <b>Benefit:</b> 75% = \$81	4.65 85% = \$1001.50
	MANDIBLE, fixation by intermaxillary	wiring, excluding wiring for obesity
45900	<b>Fee:</b> \$245.00 <b>Benefit:</b> 75% = \$18	3.75 85% = \$208.25
45939	PERIPHERAL BRANCHES OF THE T (Assist.)	RIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.)

T8. SUF	RGICAL OPERAT	IONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$454.25	<b>Benefit:</b> 75% = \$340.70	85% = \$386.15
	MANDIBLE, tre	eatment of a dislocation of, 1	requiring open reduction (Anaes.)
45945	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45	85% = \$102.55
	MAXILLA, uni	ateral or bilateral, treatment	of fracture of, not requiring splinting
45975	(See para TN.8.11 <b>Fee:</b> \$131.25	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$98.45	
	MANDIBLE, tro	eatment of fracture of, not re	equiring splinting
45978	(See para TN.8.11 <b>Fee:</b> \$160.40	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$120.30	
	ZYGOMATIC I	BONE, treatment of fracture	of, not requiring surgical reduction
45981	(See para TN.8.11 <b>Fee:</b> \$87.00	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$65.25	
		tment of a complicated fract not involving plate(s) (Anaes	ture of, involving viscera, blood vessels or nerves requiring s.) (Assist.)
45984	Fee: \$626.50	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$469.90	85% = \$541.80
		eatment of a complicated fra eduction not involving plate	acture of, involving viscera, blood vessels or nerves, (s) (Anaes.) (Assist.)
45987	(See para TN.8.11 <b>Fee:</b> \$626.50	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$469.90	<del>-</del> - • ·
		tment of a complicated fract nvolving the use of plate(s)	ture of, involving viscera, blood vessels or nerves requiring (Anaes.) (Assist.)
45990	(See para TN.8.11 <b>Fee:</b> \$855.75	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$641.85	<del>-</del> -
		eatment of a complicated fra eduction involving the use o	acture of, involving viscera, blood vessels or nerves, f plate(s) (Anaes.) (Assist.)
45993	(See para TN.8.11 <b>Fee:</b> \$855.75	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$641.85	<del>-</del> - • ·
	MANDIBLE, tro	eatment of a closed fracture	of, involving a joint surface (Anaes.)
45996	(See para TN.8.11 <b>Fee:</b> \$242.60	0 of explanatory notes to this C <b>Benefit:</b> 75% = \$181.95	
T8. SUF	RGICAL OPERAT	TIONS	14. HAND SURGERY
	Group T8. Surg	ical Operations	
		Sub	group 14. Hand Surgery
	Note: Items 463	00 to 46534 are restricted to	o surgery on the hand/s.
46300	INTER-PHALA	NGEAL JOINT or METAC	CARPOPHALANGEAL JOINT, arthrodesis of, with

T8. SUF	RGICAL OPERAT	IONS	14. HAND SURGERY
	synovectomy if p	performed (Anaes.) (Assist.)	
	<b>Fee:</b> \$343.80	<b>Benefit:</b> 75% = \$257.85	
		ARPAL JOINT, arthrodesis of, with	synovectomy if performed (Anaes.) (Assist.)
46303	Fee: \$382.10	<b>Benefit:</b> 75% = \$286.60	
	INTERPHALAN		ALANGEAL JOINT, interposition arthroplasty of ray (Anaes.) (Assist.)
46306	Fee: \$534.90	<b>Benefit:</b> 75% = \$401.20	
			HALANGEAL JOINT - volar plate arthroplasty for gnment on the 1 ray (Anaes.) (Assist.)
46307	Fee: \$534.90	<b>Benefit:</b> 75% = \$401.20	
		emiarthroplasty of, including associat	ALANGEAL JOINT, total replacement ed synovectomy, tendon transfer or realignment -
46309	<b>Fee:</b> \$534.90	<b>Benefit:</b> 75% = \$401.20	
		emiarthroplasty of, including associat	ALANGEAL JOINT, total replacement ed synovectomy, tendon transfer or realignment -
46312	Fee: \$687.80	<b>Benefit:</b> 75% = \$515.85	
		emiarthroplasty of, including associat	ALANGEAL JOINT, total replacement ed synovectomy, tendon transfer or realignment -
46315	Fee: \$917.00	<b>Benefit:</b> 75% = \$687.75	
		emiarthroplasty of, including associat	ALANGEAL JOINT, total replacement ed synovectomy, tendon transfer or realignment -
46318	<b>Fee:</b> \$1,146.30	<b>Benefit:</b> 75% = \$859.75	
	arthroplasty or h		HALANGEAL JOINT, total replacement ed synovectomy, tendon transfer or realignment -
46321	Fee: \$1,375.55	<b>Benefit:</b> 75% = \$1031.70 85% =	\$1290.85
	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.)		
46324	Fee: \$820.25	<b>Benefit:</b> 75% = \$615.20	
			ARTHROPLASTY using adjacent tendon or realignment when performed (Anaes.) (Assist.)
46325	Fee: \$856.00	<b>Benefit:</b> 75% = \$642.00	
	INTER-PHALA	NGEAL JOINT or METACARPOPH	ALANGEAL JOINT, arthrotomy of (Anaes.)
46327	Fee: \$206.40	<b>Benefit:</b> 75% = \$154.80 85% = \$	175.45
46330			ALANGEAL JOINT, ligamentous or capsular

T8. SUF	RGICAL OPERAT	TIONS 14. HAND SURGERY
	repair with or wi	ithout arthrotomy (Anaes.) (Assist.)
	Fee: \$351.65	<b>Benefit:</b> 75% = \$263.75
		NGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using or implant (Anaes.) (Assist.)
46333	Fee: \$573.05	<b>Benefit:</b> 75% = \$429.80
		NGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, debridement of, not being a service associated with any procedure related to that joint .)
46336	Fee: \$267.50	<b>Benefit:</b> 75% = \$200.65 85% = \$227.40
	EXTENSOR TE	ENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.)
46339	Fee: \$473.65	<b>Benefit:</b> 75% = \$355.25 85% = \$402.65
	DISTAL RADIO (Anaes.) (Assist	OULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of .)
46342	Fee: \$473.65	<b>Benefit:</b> 75% = \$355.25
		OULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous excision of distal ulna, when performed (Anaes.) (Assist.)
46345	Fee: \$573.05	<b>Benefit:</b> 75% = \$429.80
	DIGIT, synovec	tomy of flexor tendon or tendons - 1 digit (Anaes.)
46348	Fee: \$248.35	<b>Benefit:</b> 75% = \$186.30 85% = \$211.10
	DIGIT, synovec	tomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.)
46351	Fee: \$370.65	<b>Benefit:</b> 75% = \$278.00
	DIGIT, synovec	tomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.)
46354	Fee: \$496.65	<b>Benefit:</b> 75% = \$372.50
		tomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.)
46357	Fee: \$618.95	<b>Benefit:</b> 75% = \$464.25
.0007		tomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.)
46360	<b>Fee:</b> \$745.10	<b>Benefit:</b> 75% = \$558.85
		ATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS
46363	Fee: \$213.95	<b>Benefit:</b> 75% = \$160.50 85% = \$181.90
	DUPUYTREN'S	S CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.)
46366	Fee: \$129.95	<b>Benefit:</b> 75% = \$97.50 85% = \$110.50
	DUPUYTREN'S	S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.)
46369	Fee: \$213.95	<b>Benefit:</b> 75% = \$160.50 85% = \$181.90
46372		S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand

T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY
	(Anaes.) (Assist.	)
	Fee: \$434.80	<b>Benefit:</b> 75% = \$326.10 85% = \$369.60
	DUPUYTREN'S hand (Anaes.) (A	CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 assist.)
46375	Fee: \$515.80	<b>Benefit:</b> 75% = \$386.85 85% = \$438.45
		CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of Anaes.) (Assist.)
46378	<b>Fee:</b> \$687.80	<b>Benefit:</b> 75% = \$515.85
		NGEAL JOINT, joint capsule release when performed in conjunction with operation for stracture - each procedure (Anaes.) (Assist.)
46381	Fee: \$305.60	<b>Benefit:</b> 75% = \$229.20
		imilar local flap procedure) when performed in conjunction with operation for tracture - 1 such procedure (Anaes.) (Assist.)
46384	Fee: \$305.60	<b>Benefit:</b> 75% = \$229.20
		CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - urrence in that ray (Anaes.) (Assist.)
46387	Fee: \$630.55	<b>Benefit:</b> 75% = \$472.95 85% = \$545.85
		CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - urrence in those rays (Anaes.) (Assist.)
46390	Fee: \$840.75	<b>Benefit:</b> 75% = \$630.60
		CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of on for recurrence in those rays (Anaes.) (Assist.)
46393	<b>Fee:</b> \$974.35	<b>Benefit:</b> 75% = \$730.80
		METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services '933 or 47936 apply (Anaes.) (Assist.)
46396	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15 85% = \$284.65
	PHALANX OR (Assist.)	METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.)
46399	Fee: \$526.10	<b>Benefit:</b> 75% = \$394.60
	PHALANX or M graft material (A	METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of naes.) (Assist.)
46402	<b>Fee:</b> \$526.10	<b>Benefit:</b> 75% = \$394.60
		METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal uding obtaining of graft material (Anaes.) (Assist.)
46405	Fee: \$642.00	<b>Benefit:</b> 75% = \$481.50
	TENDON, recon	nstruction of, by tendon graft (Anaes.) (Assist.)
46408	Fee: \$703.05	<b>Benefit:</b> 75% = \$527.30

T8. SUF	RGICAL OPERATI	ONS 14. HAND SURGERY
	FLEXOR TEND	ON PULLEY, reconstruction of, by graft (Anaes.) (Assist.)
46411	Fee: \$412.65	<b>Benefit:</b> 75% = \$309.50
	ARTIFICIAL TE (Assist.)	ENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.)
46414	Fee: \$534.80	<b>Benefit:</b> 75% = \$401.10 85% = \$454.60
	TENDON transfe	er for restoration of hand function, each transfer (Anaes.) (Assist.)
46417	Fee: \$496.65	<b>Benefit:</b> 75% = \$372.50
	EXTENSOR TE	NDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.)
46420	Fee: \$207.85	<b>Benefit:</b> 75% = \$155.90 85% = \$176.70
	EXTENSOR TE	NDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.)
46423	Fee: \$332.40	<b>Benefit:</b> 75% = \$249.30 85% = \$282.55
		ON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon
46426	Fee: \$343.80	<b>Benefit:</b> 75% = \$257.85
	FLEXOR TEND (Anaes.) (Assist.)	ON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon
46429	Fee: \$420.25	<b>Benefit:</b> 75% = \$315.20 85% = \$357.25
	FLEXOR TEND	ON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)
46432	Fee: \$458.55	<b>Benefit:</b> 75% = \$343.95
	FLEXOR TEND	ON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)
46435	Fee: \$534.90	<b>Benefit:</b> 75% = \$401.20
	MALLET FINGI	ER, closed pin fixation of (Anaes.)
46438	<b>Fee:</b> \$137.60	<b>Benefit:</b> 75% = \$103.20 85% = \$117.00
	MALLET FINGI	ER, open repair of, including pin fixation when performed (Anaes.) (Assist.)
46441	Fee: \$332.40	<b>Benefit:</b> 75% = \$249.30 85% = \$282.55
		ER with intra articular fracture involving more than one third of base of terminal eduction (Anaes.) (Assist.)
46442	Fee: \$285.35	<b>Benefit:</b> 75% = \$214.05
	BOUTONNIERE	E DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.)
46444	Fee: \$496.65	<b>Benefit:</b> 75% = \$372.50
		E DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.)
46447	<b>Fee:</b> \$618.95	<b>Benefit:</b> 75% = \$464.25
		NDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.)
46450	Fee: \$229.30	<b>Benefit:</b> 75% = \$172.00
TU+30	<b>Γ</b> (C. ψ229.30	<b>Denotite</b> $13/0 - \phi 1/2.00$

T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY	
	FLEXOR TEND	ON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.)	
46453	<b>Fee:</b> \$382.10	<b>Benefit:</b> 75% = \$286.60	
	FINGER, percut	aneous tenotomy of (Anaes.)	
46456	Fee: \$99.35	<b>Benefit:</b> 75% = \$74.55 85% = \$84.45	
	OPERATION fo	r OSTEOMYELITIS on distal phalanx (Anaes.)	
46459	<b>Fee:</b> \$191.05	<b>Benefit:</b> 75% = \$143.30 85% = \$162.40	
	OPERATION fo (Assist.)	r OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.)	
46462	Fee: \$305.60	<b>Benefit:</b> 75% = \$229.20 85% = \$259.80	
	AMPUTATION	of a supernumerary complete digit (Anaes.)	
46464	Fee: \$229.30	<b>Benefit:</b> 75% = \$172.00 85% = \$194.95	
		of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and sue cover (Anaes.)	
46465	Fee: \$229.30	<b>Benefit:</b> 75% = \$172.00 85% = \$194.95	
	AMPUTATION tissue cover (An	of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46468	Fee: \$401.20	<b>Benefit:</b> 75% = \$300.90	
	AMPUTATION tissue cover (An	of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46471	Fee: \$573.05	<b>Benefit:</b> 75% = \$429.80 85% = \$488.35	
	AMPUTATION tissue cover (An	of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46474	Fee: \$745.10	<b>Benefit:</b> 75% = \$558.85	
	AMPUTATION tissue cover (An	of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46477	Fee: \$917.00	<b>Benefit:</b> 75% = \$687.75	
	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.)		
46480	Fee: \$382.10	<b>Benefit:</b> 75% = \$286.60 85% = \$324.80	
	REVISION of A	MPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.)	
46483	Fee: \$305.60	<b>Benefit:</b> 75% = \$229.20 85% = \$259.80	
		arate reconstruction of nail bed laceration using magnification, undertaken in the of a hospital (Anaes.)	
46486	Fee: \$229.30	<b>Benefit:</b> 75% = \$172.00	
		ondary exploration and accurate repair of nail bed deformity using magnification, e operating theatre of a hospital (Anaes.) (Assist.)	
46489	Fee: \$267.50	<b>Benefit:</b> 75% = \$200.65	

T8. SUF	RGICAL OPERAT	IONS	14. HAND SURGERY
		E OF DIGITS OF HAND, flexor or extensor, correction ocutaneous tissue (Anaes.) (Assist.)	of, involving tissues deeper
46492	Fee: \$366.85	<b>Benefit:</b> 75% = \$275.15	
	GANGLION OF in this Group app	HAND, excision of, not being a service associated with blies (Anaes.)	a service to which another item
46494	Fee: \$223.45	<b>Benefit:</b> 75% = \$167.60 85% = \$189.95	
		MUCOUS CYST OF DISTAL DIGIT, excision of, other which item 30107 applies (Anaes.)	er than a service associated
46495	Fee: \$206.40	<b>Benefit:</b> 75% = \$154.80 85% = \$175.45	
		FLEXOR TENDON SHEATH, excision of, other than a item 30107 applies (Anaes.)	service associated with a
46498	Fee: \$223.45	<b>Benefit:</b> 75% = \$167.60 85% = \$189.95	
		DORSAL WRIST JOINT, excision of, other than a server applies (Anaes.) (Assist.)	ice associated with a service to
46500	Fee: \$267.50	<b>Benefit:</b> 75% = \$200.65 85% = \$227.40	
		VOLAR WRIST JOINT, excision of, other than a servic 7 applies (Anaes.) (Assist.)	e associated with a service to
46501	Fee: \$334.45	<b>Benefit:</b> 75% = \$250.85 85% = \$284.30	
		ANGLION OF DORSAL WRIST JOINT, excision of, o which item 30107 applies (Anaes.) (Assist.)	ther than a service associated
46502	<b>Fee:</b> \$307.80	<b>Benefit:</b> 75% = \$230.85 85% = \$261.65	
		ANGLION OF VOLAR WRIST JOINT, excision of, oth which item 30107 applies (Anaes.) (Assist.)	ner than a service associated
46503	Fee: \$384.45	<b>Benefit:</b> 75% = \$288.35 85% = \$326.80	
	NEUROVASCU	LAR ISLAND FLAP, for pulp innervation (Anaes.) (Ass	ist.)
46504	Fee: \$1,123.25	<b>Benefit:</b> 75% = \$842.45 85% = \$1038.55	
		, transposition or transfer of, on vascular pedicle, comple	te procedure (Anaes.) (Assist.)
46507	Fee: \$1,306.80	<b>Benefit:</b> 75% = \$980.10	
		LY, surgical reduction of enlarged elements - each digit	(Anaes.) (Assist.)
46510	<b>Fee:</b> \$356.60	<b>Benefit:</b> 75% = \$267.45	
		OF FINGER OR THUMB, removal of, not being a servi	ce to which item 46516 applies
46513	Fee: \$57.40	<b>Benefit:</b> 75% = \$43.05 85% = \$48.80	
	DIGITAL NAIL	OF FINGER OR THUMB, removal of, in the operating to	theatre of a hospital (Anaes.)
46516	Fee: \$114.65	<b>Benefit:</b> 75% = \$86.00	
	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding aftercare) (Anaes.)		
46519			

T8. SUF	RGICAL OPERAT	IONS	14. HAND SURGERY	
	Fee: \$143.50	<b>Benefit:</b> 75% = \$107.65	85% = \$122.00	
	FLEXOR TEND (Anaes.) (Assist.		OR THUMB, open operation and drainage for infection	
46522	Fee: \$427.95	<b>Benefit:</b> 75% = \$321.00		
			A OF HAND, incision for, when performed in an operating hich another item in this Group applies (excluding after-	
46525	<b>Fee:</b> \$57.40	<b>Benefit:</b> 75% = \$43.05	85% = \$48.80	
		AIL OF FINGER OR THU and portion of the nail bed (	MB, wedge resection for, including removal of segment of Anaes.)	
46528	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15	85% = \$146.40	
		AIL OF FINGER OR THUE	MB, partial resection of nail, including phenolisation but	
46531	Fee: \$86.50	<b>Benefit:</b> 75% = \$64.90	85% = \$73.55	
	NAIL PLATE IN	NJURY OR DEFORMITY, 1	radical excision of nail germinal matrix (Anaes.)	
46534	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45	85% = \$203.40	
T8. SUF	RGICAL OPERAT	IONS	15. ORTHOPAEDIC	
	Group T8. Surgi	cal Operations		
		Sub	group 15. Orthopaedic	
		TREATM	ENT OF DISLOCATIONS	
	MANDIBLE, tre	atment of dislocation of, by	closed reduction (Anaes.)	
47000	Fee: \$71.80	<b>Benefit:</b> 75% = \$53.85	85% = \$61.05	
	CLAVICLE, trea	atment of dislocation of, by	closed reduction (Anaes.)	
47003	<b>Fee:</b> \$86.15	<b>Benefit:</b> 75% = \$64.65	85% = \$73.25	
	CLAVICLE, trea	atment of dislocation of, by	open reduction (Anaes.)	
47006	Fee: \$172.95	<b>Benefit:</b> 75% = \$129.75	85% = \$147.05	
	SHOULDER, tre item 47012 appli		quiring general anaesthesia, not being a service to which	
47009	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15	85% = \$146.40	
	SHOULDER, tre (Assist.)	eatment of dislocation of, rec	quiring general anaesthesia, open reduction (Anaes.)	
47012	Fee: \$344.25	<b>Benefit:</b> 75% = \$258.20		
	SHOULDER, treatment of dislocation of, not requiring general anaesthesia			
47015	Fee: \$86.15	<b>Benefit:</b> 75% = \$64.65	85% = \$73.25	
47018		ent of dislocation of, by clos		

PER	URG	ERATIONS 15. ORTHOPAEDIC
00.75		.75 <b>Benefit:</b> 75% = \$150.60 85% = \$170.65
/, trea		treatment of dislocation of, by open reduction (Anaes.) (Assist.)
57.80		.80 <b>Benefit:</b> 75% = \$200.85
		LNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not ervice associated with fracture or dislocation in the same region (Anaes.)
00.75		.75 <b>Benefit:</b> 75% = \$150.60 85% = \$170.65
		LNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not ervice associated with fracture or dislocation in the same region (Anaes.) (Assist.)
57.80	,	.80 <b>Benefit:</b> 75% = \$200.85
		, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of n of, by closed reduction (Anaes.)
00.75	)	.75 <b>Benefit:</b> 75% = \$150.60 85% = \$170.65
		, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of n of, by open reduction (Anaes.) (Assist.)
57.80		.80 <b>Benefit:</b> 75% = \$200.85 85% = \$227.65
PHAL		HALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)
5.15		Benefit: 75% = \$64.65 85% = \$73.25
PHAL		HALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)
14.65	,	.65 <b>Benefit:</b> 75% = \$86.00 85% = \$97.50
CARP		ARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)
14.65	,	.65 <b>Benefit:</b> 75% = \$86.00 85% = \$97.50
		ARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)
53.15		.15 <b>Benefit:</b> 75% = \$114.90 85% = \$130.20
		ment of dislocation of, by closed reduction (Anaes.)
30.00		.00 <b>Benefit:</b> 75% = \$247.50 85% = \$280.50 ment of dislocation of, by open reduction (Anaes.) (Assist.)
39.90		
KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.)		
30.00		
LA, tr		A, treatment of dislocation of, by closed reduction (Anaes.)
29.05	,	.05 <b>Benefit:</b> 75% = \$96.80 85% = \$109.70
LA, tr		A, treatment of dislocation of, by open reduction (Anaes.)
72.20	)	.20 <b>Benefit:</b> 75% = \$129.15 85% = \$146.40
or T		or TARSUS, treatment of dislocation of, by closed reduction (Anaes.)
58.25		.25 <b>Benefit:</b> 75% = \$193.70 85% = \$219.55
72.20 E or T <i>A</i>	)	.20 <b>Benefit:</b> 75% = \$129.15 85% = \$146.40 or TARSUS, treatment of dislocation of, by closed reduction (Anaes.)

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC		
	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.)		
47066	<b>Fee:</b> \$344.25 <b>Benefit:</b> 75% = \$258.20		
	TOE, treatment of dislocation of, by closed reduction (Anaes.)		
47069	<b>Fee:</b> \$71.80 <b>Benefit:</b> 75% = \$53.85 85% = \$61.05		
	TOE, treatment of dislocation of, by open reduction (Anaes.)		
47072	<b>Fee:</b> \$95.50 <b>Benefit:</b> 75% = \$71.65 85% = \$81.20		
	TREATMENT OF FRACTURES		
	Phalanx, middle or proximal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47304, 47307, 47310, 47313, 47316 or 47319 (Anaes.)		
47301	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$88.20 <b>Benefit:</b> 75% = \$66.15 85% = \$75.00		
	Metacarpal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provided on the same occasion as a service described in item 47301, 47307, 47310, 47313, 47316 or 47319 (Anaes.)		
47204	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40		
47304	Phalanx or metacarpal, treatment of fracture of, by closed reduction with percutaneous K wire fixation		
	(Anaes.) (Assist.)		
	(See para TN.8.124 of explanatory notes to this Category)		
47307	Fee: \$203.20 Benefit: 75% = \$152.40		
	Phalanx or metacarpal, treatment of fracture of, by open reduction with fixation (Anaes.) (Assist.)		
47310	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$335.30 <b>Benefit:</b> 75% = \$251.50		
	Phalanx or metacarpal, treatment of intra articular fracture of, by closed reduction with percutaneous K wire fixation (Anaes.) (Assist.)		
	(See para TN.8.124 of explanatory notes to this Category)		
47313	Fee: \$325.10 Benefit: 75% = \$243.85		
	Phalanx or metacarpal, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47319 applies (Anaes.) (Assist.)		
47316	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$645.15 <b>Benefit:</b> 75% = \$483.90		
	Middle phalanx, proximal end, treatment of intra articular fracture of, by open reduction with fixation, not provided on the same occasion as a service to which item 47316 applies (Anaes.) (Assist.)		
47319	(See para TN.8.124 of explanatory notes to this Category) <b>Fee:</b> \$660.40 <b>Benefit:</b> 75% = \$495.30		
	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.)		
47348	<b>Fee:</b> \$95.50 <b>Benefit:</b> 75% = \$71.65 85% = \$81.20		
	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.)		
47351	<b>Fee:</b> \$239.25 <b>Benefit:</b> 75% = \$179.45 85% = \$203.40		

T8. SUF	RGICAL OPERATI	ONS	15. ORTHOPAEDIC
	CARPAL SCAP (Anaes.)	HOID, treatment of fracture of, not being	a service to which item 47357 applies
47354	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15 85% = \$146.	40
	CARPAL SCAP	HOID, treatment of fracture of, by open r	reduction (Anaes.) (Assist.)
47357	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95 85% = \$325.	20
			of fracture of, by cast immobilisation, other 62, 47364, 47367, 47370 or 47373 applies
47361	(See para TN.8.124 <b>Fee:</b> \$133.95	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$100.50 85% = \$113.	90
	general or major		of fracture of, by closed reduction, requiring infiltration, other than a service associated or 47373 applies (Anaes.)
47362	(See para TN.8.124 <b>Fee:</b> \$200.75	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$150.60 85% = \$170.	65
			reatment of fracture of, by open reduction with which item 47361 or 47362 applies (Anaes.)
47364	(See para TN.8.124 <b>Fee:</b> \$284.50	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$213.40	
		d of, treatment of fracture of, by closed red with a service to which item 47361 or	eduction with percutaneous fixation, other than 47362 applies (Anaes.) (Assist.)
47367	(See para TN.8.124 <b>Fee:</b> \$227.20	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$170.40	
		d of, treatment of intra articular fracture of with a service to which item 47361 or 4	of, by open reduction with fixation, other than a 17362 applies (Anaes.) (Assist.)
47370	(See para TN.8.124 <b>Fee:</b> \$412.50	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$309.40	
		of, treatment of intra articular fracture of, d with a service to which item 47361 or 4	by open reduction with fixation, other than a 17362 applies (Anaes.) (Assist.)
47373	(See para TN.8.124 <b>Fee:</b> \$294.65	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$221.00	
		NA, shaft of, treatment of fracture of, by 1, 47384, 47385 or 47386 applies (Anaes	cast immobilisation, not being a service to .)
47378	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15 85% = \$146.	40
	RADIUS OR UL theatre of a hospi	•	closed reduction undertaken in the operating
47381	Fee: \$258.25	<b>Benefit:</b> 75% = \$193.70	
	RADIUS OR UL	NA, shaft of, treatment of fracture of, by	open reduction (Anaes.) (Assist.)
47384	Fee: \$344.25	<b>Benefit:</b> 75% = \$258.20	
47385	RADIUS OR UL		conjunction with dislocation of distal radio- lonteggia injury), by closed reduction

10. 301	RGICAL OPERAT	IONS 15. ORTHOPAEDIC	
	undertaken in the	e operating theatre of a hospital (Anaes.) (Assist.)	
	Fee: \$296.40	<b>Benefit:</b> 75% = \$222.30	
		NA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal (Assist.)	
47386	Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70	
		JLNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to 0 or 47393 applies (Anaes.) (Assist.)	
47387	<b>Fee:</b> \$277.30	<b>Benefit:</b> 75% = \$208.00 85% = \$235.75	
		JLNA, shafts of, treatment of fracture of, by closed reduction undertaken in the of a hospital (Anaes.)	
47390	<b>Fee:</b> \$416.10	<b>Benefit:</b> 75% = \$312.10	
	RADIUS AND U	JLNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	
47393	Fee: \$554.75	<b>Benefit:</b> 75% = \$416.10	
	OLECRANON,	treatment of fracture of, not being a service to which item 47399 applies (Anaes.)	
47396	Fee: \$191.20	<b>Benefit:</b> 75% = \$143.40 85% = \$162.55	
	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.)		
47399	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95	
17377	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.)		
47402	Fee: \$286.85	<b>Benefit:</b> 75% = \$215.15 85% = \$243.85	
	RADIUS, treatment of fracture of head or neck of, closed reduction of (Anaes.)		
47405	Fee: \$191.20	<b>Benefit:</b> 75% = \$143.40 85% = \$162.55	
		ent of fracture of head or neck of, open reduction of, including internal fixation and erformed (Anaes.) (Assist.)	
47408	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95	
	HUMERUS, trea (Anaes.)	ttment of fracture of tuberosity of, not being a service to which item 47417 applies	
47411	<b>Fee:</b> \$114.65	<b>Benefit:</b> 75% = \$86.00 85% = \$97.50	
	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.)		
47414	Fee: \$229.60	<b>Benefit:</b> 75% = \$172.20 85% = \$195.20	
	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.)		
47417	Fee: \$267.80	<b>Benefit:</b> 75% = \$200.85 85% = \$227.65	
	HUMERUS, trea reduction (Anaes	atment of fracture of tuberosity of, and associated dislocation of shoulder, by open s.) (Assist.)	
	Fee: \$526.10	<b>Benefit:</b> 75% = \$394.60	

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	HUMERUS, pro 47432 applies (A	eximal, treatment of fracture of, not being a service to which item 47426, 47429 or Anaes.)
47423	Fee: \$219.95	<b>Benefit:</b> 75% = \$165.00 85% = \$187.00
	HUMERUS, pro of a hospital (An	eximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre tases.)
47426	<b>Fee:</b> \$330.00	<b>Benefit:</b> 75% = \$247.50
	HUMERUS, pro	oximal, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47429	<b>Fee:</b> \$439.90	<b>Benefit:</b> 75% = \$329.95
	HUMERUS, pro	eximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)
47432	Fee: \$549.95	<b>Benefit:</b> 75% = \$412.50
	HUMERUS, pro reduction (Anaes	eximal, treatment of fracture of, and associated dislocation of shoulder, by closed s.) (Assist.)
47435	<b>Fee:</b> \$420.90	<b>Benefit:</b> 75% = \$315.70 85% = \$357.80
	HUMERUS, pro reduction (Anaes	oximal, treatment of fracture of, and associated dislocation of shoulder, by open s.) (Assist.)
47438	<b>Fee:</b> \$669.70	<b>Benefit:</b> 75% = \$502.30
	HUMERUS, pro open reduction (	eximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by Anaes.) (Assist.)
47441	Fee: \$836.95	<b>Benefit:</b> 75% = \$627.75
	HUMERUS, sha (Anaes.)	Ift of, treatment of fracture of, not being a service to which item 47447 or 47450 applies
47444	Fee: \$229.60	<b>Benefit:</b> 75% = \$172.20 85% = \$195.20
	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the opera a hospital (Anaes.)	
47447	Fee: \$344.25	<b>Benefit:</b> 75% = \$258.20
	HUMERUS, sha	off of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)
47450	<b>Fee:</b> \$459.20	<b>Benefit:</b> 75% = \$344.40
	HUMERUS, sha	off of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.)
47451	Fee: \$553.50	<b>Benefit:</b> 75% = \$415.15
		tal, (supracondylar or condylar), treatment of fracture of, not being a service to which 7459 applies (Anaes.) (Assist.)
47453	<b>Fee:</b> \$267.80	<b>Benefit:</b> 75% = \$200.85 85% = \$227.65
		tal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken theatre of a hospital (Anaes.)
47456	<b>Fee:</b> \$401.85	<b>Benefit:</b> 75% = \$301.40
		tal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken theatre of a hospital (Anaes.) (Assist.)

GICAL OPERATI	ONS 15. ORTHOPAEDIC		
<b>Fee:</b> \$535.70	<b>Benefit:</b> 75% = \$401.80		
CLAVICLE, trea	ttment of fracture of, not being a service to which item 47465 applies (Anaes.)		
Fee: \$114.65	<b>Benefit:</b> 75% = \$86.00 85% = \$97.50		
CLAVICLE, treatment of fracture of, by open reduction (Anaes.) (Assist.)			
Fee: \$229 60	<b>Benefit:</b> 75% = \$172.20 85% = \$195.20		
	tment of fracture of, not being a service to which item 47467 applies (Anaes.)		
Fee: \$114.65	<b>Benefit:</b> 75% = \$86.00 85% = \$97.50		
	tment of fracture of, by open reduction (Anaes.)		
	<b>Benefit:</b> 75% = \$172.20		
	t or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)		
<u> </u>	<b>Benefit:</b> 75% = \$329.95  85% = \$373.95		
	), treatment of fracture of - each attendance		
	<b>Benefit:</b> 75% = \$32.80  85% = \$37.15		
PELVIC RING,	treatment of fracture of, not involving disruption of pelvic ring or acetabulum		
Fee: \$191.20	<b>Benefit:</b> 75% = \$143.40 85% = \$162.55		
PELVIC RING, 1	treatment of fracture of, with disruption of pelvic ring or acetabulum		
Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40		
PELVIC RING, 1	treatment of fracture of, requiring traction (Anaes.) (Assist.)		
Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70		
PELVIC RING,	treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.)		
<b>Fee:</b> \$573.90	<b>Benefit:</b> 75% = \$430.45		
	treatment of fracture of, by open reduction and involving internal fixation of anterior		
segment, including diastasis of pubic symphysis (Anaes.) (Assist.)			
Fee: \$956.50	<b>Benefit:</b> 75% = \$717.40		
	treatment of fracture of, by open reduction and involving internal fixation of posterior		
segment (including	ng sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.)		
Fee: \$1,434.80	<b>Benefit:</b> 75% = \$1076.10		
ACETABULUM	t, treatment of fracture of, and associated dislocation of hip (Anaes.)		
Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40		
ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.)			
Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70 85% = \$406.55		
	, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, raction (Anaes.) (Assist.)		
Fee: \$717.35	<b>Benefit:</b> 75% = \$538.05		
	Fee: \$535.70  CLAVICLE, treates: \$114.65  CLAVICLE, treates: \$114.65  CLAVICLE, treates: \$229.60  STERNUM, treates: \$114.65  STERNUM, treates: \$229.60  SCAPULA, necks: \$229.60  SCAPULA, necks: \$439.90  RIBS (1 or more): \$60.00  Fee: \$43.70  PELVIC RING, \$60.00  Fee: \$191.20  PELVIC RING, \$60.00  Fee: \$239.25  PELVIC RING, \$60.00  Fee: \$573.90  PELVIC RING, \$60.00  Fee: \$573.90  PELVIC RING, \$60.00  Fee: \$1,434.80  ACETABULUM  ACETABULUM  (Assist.)  Fee: \$478.25  ACETABULUM  with or without to		

T8. SUF	RGICAL OPERATIONS		15. ORTHOPAEDIC
	including any osteotomy	nent of single column fracture of, by open v, osteectomy or capsulotomy required for nich item 47933 or 47936 apply (Anaes.) (	exposure and subsequent repair, and
47501	Fee: \$956.50 Ber	<b>nefit:</b> 75% = \$717.40	
	any osteotomy, osteector	nent of T-shape fracture of, by open reducing or capsulotomy required for exposure 7933 or 47936 apply (Anaes.) (Assist.)	
47504	Fee: \$1,434.80 Bei	<b>nefit:</b> 75% = \$1076.10 85% = \$1350.10	
	any osteotomy, osteector	ment of transverse fracture of, by open redumy or capsulotomy required for exposure 7933 or 47936 apply (Anaes.) (Assist.)	
47507	Fee: \$1,434.80 Ber	<b>nefit:</b> 75% = \$1076.10	
	including any osteotomy	nent of double column fracture of, by oper v, osteectomy or capsulotomy required for nich item 47933 or 47936 apply (Anaes.) (	exposure and subsequent repair, and
47510	Fee: \$1,434.80 Ben	<b>nefit:</b> 75% = \$1076.10	
		DISRUPTION, treatment of, requiring into the to which items 47501 to 47510 apply (An	
47513	Fee: \$382.55 Ber	<b>nefit:</b> 75% = \$286.95	
	FEMUR, treatment of fra	acture of, by closed reduction or traction (	(Anaes.) (Assist.)
47516	Fee: \$439.90 Ber	<b>nefit:</b> 75% = \$329.95 85% = \$373.95	
	FEMUR, treatment of tre	ochanteric or subcapital fracture of, by int	ernal fixation (Anaes.) (Assist.)
47519	Fee: \$880.05 Ber	<b>nefit:</b> 75% = \$660.05	
		ubcapital fracture of, by hemi-arthroplasty	(Anaes.) (Assist.)
47522	Fee: \$765.30 Ber	<b>nefit:</b> 75% = \$574.00	
17322	· ·	acture of, for slipped capital femoral epipl	hysis (Anaes.) (Assist.)
47525		nefit: 75% = \$660.05	• , , , ,
47323		acture of, by internal fixation or external f	Fixation (Anaes.) (Assist.)
47.520		•	(,
47528		nefit: 75% = \$574.00 acture of shaft, by intramedullary fixation	and cross fivation (Anges) (Assist)
			and cross fixation (Anacs.) (Assist.)
47531		<b>nefit:</b> 75% = \$731.70	
		n of, treatment of intra-articular (T-shaped without internal fixation of 1 or more ost	
47534	Fee: \$1,100.00 Ben	<b>nefit:</b> 75% = \$825.00	
47537		n of, treatment of fracture of, requiring int s, not being a service associated with a ser	

T8. SUF	GICAL OPERAT	IONS 15. ORTHOPAEDIC
	<b>Fee:</b> \$439.90	<b>Benefit:</b> 75% = \$329.95 85% = \$373.95
	HIP SPICA OR	SHOULDER SPICA, application of, as an independent procedure (Anaes.)
47540	<b>Fee:</b> \$219.95	<b>Benefit:</b> 75% = \$165.00 85% = \$187.00
	TIBIA, plateau o 47549 applies (A	of, treatment of medial or lateral fracture of, not being a service to which item 47546 or anaes.)
47543	Fee: \$229.60	<b>Benefit:</b> 75% = \$172.20 85% = \$195.20
	TIBIA, plateau o	of, treatment of medial or lateral fracture of, by closed reduction (Anaes.)
47546	Fee: \$344.25	<b>Benefit:</b> 75% = \$258.20 85% = \$292.65
	TIBIA, plateau o	of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.)
47549	<b>Fee:</b> \$459.20	<b>Benefit:</b> 75% = \$344.40
		of, treatment of both medial and lateral fractures of, not being a service to which item applies (Anaes.) (Assist.)
47552	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95 85% = \$325.20
	TIBIA, plateau o	of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)
47555	<b>Fee:</b> \$573.90	<b>Benefit:</b> 75% = \$430.45
	TIBIA, plateau o	of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.)
47558	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00
		treatment of fracture of, by cast immobilisation, not being a service to which item 7570 or 47573 applies (Anaes.)
47561	<b>Fee:</b> \$277.30	<b>Benefit:</b> 75% = \$208.00 85% = \$235.75
	TIBIA, shaft of, fracture (Anaes.)	treatment of fracture of, by closed reduction, with or without treatment of fibular
47564	<b>Fee:</b> \$416.10	<b>Benefit:</b> 75% = \$312.10 85% = \$353.70
	TIBIA, shaft of,	treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)
47565	Fee: \$723.80	<b>Benefit:</b> 75% = \$542.85
	TIBIA, shaft of,	treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.)
47566	Fee: \$922.60	<b>Benefit:</b> 75% = \$691.95
	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.)	
47567	Fee: \$482.95	<b>Benefit:</b> 75% = \$362.25 85% = \$410.55
	TIBIA, shaft of, (Anaes.) (Assist.	treatment of fracture of, by open reduction, with or without treatment of fibular fracture )
47570	Fee: \$554.75	<b>Benefit:</b> 75% = \$416.10 85% = \$471.55
	TIBIA, shaft of, fibula fracture (A	treatment of intra-articular fracture of, by open reduction, with or without treatment of Anaes.) (Assist.)
47573	Fee: \$693.45	<b>Benefit:</b> 75% = \$520.10

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC		
	FIBULA, treatme	nt of fracture of (Anaes.)		
47576	<b>Fee:</b> \$114.65	<b>Benefit:</b> 75% = \$86.00 85% = \$97.50		
17370		ment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)		
45.550				
47579	Fee: \$162.60	<b>Benefit:</b> 75% = \$121.95  85% = \$138.25		
	(Assist.)	nent of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.)		
47582	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15		
	PATELLA, treatr	nent of fracture of, by internal fixation (Anaes.) (Assist.)		
47585	Fee: \$430.55	<b>Benefit:</b> 75% = \$322.95		
		eatment of fracture of, by internal fixation of intra-articular fractures of femoral articular surfaces and requiring repair or reconstruction of 1 or more ligaments		
47588	Fee: \$1,338.90	<b>Benefit:</b> 75% = \$1004.20		
		eatment of fracture of, by internal fixation of intra-articular fractures of femoral al articular surfaces and requiring repair or reconstruction of 1 or more ligaments		
47591	Fee: \$1,626.25	<b>Benefit:</b> 75% = \$1219.70		
	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.)			
47594	Fee: \$219.95	<b>Benefit:</b> 75% = \$165.00 85% = \$187.00		
	ANKLE JOINT,	treatment of fracture of, by closed reduction (Anaes.)		
47597	Fee: \$330.00	<b>Benefit:</b> 75% = \$247.50 85% = \$280.50		
47377		treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis		
47600	Fee: \$439.90	<b>Benefit:</b> 75% = \$329.95		
	ANKLE JOINT, diastasis (Anaes.)	treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or (Assist.)		
47603	Fee: \$573.90	<b>Benefit:</b> 75% = \$430.45		
		OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, pplies, with or without dislocation (Anaes.)		
47606	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40		
	CALCANEUM ( (Anaes.) (Assist.)	OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation		
47609	Fee: \$358.70	<b>Benefit:</b> 75% = \$269.05 85% = \$304.90		
	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.)			
47612	<b>Fee:</b> \$416.10	<b>Benefit:</b> 75% = \$312.10 85% = \$353.70		
47615	CALCANEUM C	OR TALUS, treatment of fracture of, by open reduction, with or without dislocation		

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC	
	(Anaes.) (Assist.)		
	Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70 85% = \$406.55	
	CALCANEUM (dislocation (Anae	OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without es.) (Assist.)	
47618	Fee: \$597.85	<b>Benefit:</b> 75% = \$448.40	
	TARSO-METAT dislocation (Anae	CARSAL, treatment of intra-articular fracture of, by closed reduction, with or without es.) (Assist.)	
47621	Fee: \$416.10	<b>Benefit:</b> 75% = \$312.10 85% = \$353.70	
	TARSO-METAT (Anaes.) (Assist.)	CARSAL, treatment of fracture of, by open reduction, with or without dislocation	
47624	<b>Fee:</b> \$573.90	<b>Benefit:</b> 75% = \$430.45	
	TARSUS (exclud	ling calcaneum or talus), treatment of fracture of (Anaes.)	
47627	Fee: \$162.60	<b>Benefit:</b> 75% = \$121.95 85% = \$138.25	
	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or withou dislocation (Anaes.) (Assist.)		
47630	Fee: \$344.25	<b>Benefit:</b> 75% = \$258.20 85% = \$292.65	
	METATARSAL	, 1 of, treatment of fracture of (Anaes.)	
47633	Fee: \$114.65	<b>Benefit:</b> 75% = \$86.00 85% = \$97.50	
	METATARSAL	, 1 of, treatment of fracture of, by closed reduction (Anaes.)	
47636	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15 85% = \$146.40	
	METATARSAL	, 1 of, treatment of fracture of, by open reduction (Anaes.)	
47639	Fee: \$229.60	<b>Benefit:</b> 75% = \$172.20 85% = \$195.20	
	METATARSALS, 2 of, treatment of fracture of (Anaes.)		
47642	Fee: \$153.15	<b>Benefit:</b> 75% = \$114.90 85% = \$130.20	
	METATARSAL	S, 2 of, treatment of fracture of, by closed reduction (Anaes.)	
47645	Fee: \$229.60	<b>Benefit:</b> 75% = \$172.20 85% = \$195.20	
	METATARSAL	S, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	
47648	Fee: \$305.85	<b>Benefit:</b> 75% = \$229.40	
	METATARSALS, 3 or more of, treatment of fracture of (Anaes.)		
47651	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40	
		S, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.)	
47654	<b>Fee:</b> \$358.70	<b>Benefit:</b> 75% = \$269.05 85% = \$304.90	
		S, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.)	
47657	Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70	
+/05/	I CC. \$4/0.23	DCRCII. 1370 — \$330.10	

T8. SUF	RGICAL OPERAT	ONS 15. ORTHOPAEDIC		
	PHALANX OF	GREAT TOE, treatment of fracture of, by closed reduction (Anaes.)		
47663	<b>Fee:</b> \$143.50	<b>Benefit:</b> 75% = \$107.65 85% = \$122.00		
	PHALANX OF	GREAT TOE, treatment of fracture of, by open reduction (Anaes.)		
47666	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40		
	PHALANX OF	TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.)		
47672	Fee: \$114.65	<b>Benefit:</b> 75% = \$86.00 85% = \$97.50		
	PHALANX OF (Anaes.)	TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction		
47678	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15 85% = \$146.40		
	BONE GRAFT, small quantity (A	harvesting of, via separate incision, in conjunction with another service - autogenous - naes.)		
47726	Fee: \$143.50	<b>Benefit:</b> 75% = \$107.65		
	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.)			
47729	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45		
	VASCULARISE (Anaes.) (Assist.	D PEDICLE BONE GRAFT, harvesting of, in conjunction with another service		
47732	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95		
	NASAL BONES each attendance	, treatment of fracture of, not being a service to which item 47738 or 47741 applies -		
47735	<b>Fee:</b> \$43.75	<b>Benefit:</b> 75% = \$32.85 85% = \$37.20		
	NASAL BONES, treatment of fracture of, by reduction (Anaes.)			
47738	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40		
	NASAL BONES	, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.)		
47741	Fee: \$488.05	<b>Benefit:</b> 75% = \$366.05		
		ment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or (Anaes.) (Assist.)		
47753	<b>Fee:</b> \$413.15	<b>Benefit:</b> 75% = \$309.90		
	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.)			
47756	<b>Fee:</b> \$413.15	<b>Benefit:</b> 75% = \$309.90		
	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.)			
47762	Fee: \$242.60	<b>Benefit:</b> 75% = \$181.95 85% = \$206.25		
		ONE, treatment of fracture of, requiring surgical reduction and involving internal or at 1 site (Anaes.) (Assist.)		
47765	Fee: \$398.35	<b>Benefit:</b> 75% = \$298.80		

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIO
		NE, treatment of fracture of, requiring surgical reduction and involving internal or both at 2 sites (Anaes.) (Assist.)
47768	Fee: \$488.05	<b>Benefit:</b> 75% = \$366.05
		NE, treatment of fracture of, requiring surgical reduction and involving internal or both at 3 sites (Anaes.) (Assist.)
47771	<b>Fee:</b> \$560.70	<b>Benefit:</b> 75% = \$420.55
	MAXILLA, treat	nent of fracture of, requiring open operation (Anaes.) (Assist.)
47774	Fee: \$442.60	<b>Benefit:</b> 75% = \$331.95
	MANDIBLE, tre	ment of fracture of, requiring open reduction (Anaes.) (Assist.)
47777	Fee: \$442.60	<b>Benefit:</b> 75% = \$331.95
	MAXILLA, treat (Anaes.) (Assist.)	nent of fracture of, requiring open reduction and internal fixation not involving plate(s
47780	Fee: \$575.40	<b>Benefit:</b> 75% = \$431.55
	MANDIBLE, tre plate(s) (Anaes.)	ment of fracture of, requiring open reduction and internal fixation not involving Assist.)
47783	Fee: \$575.40	<b>Benefit:</b> 75% = \$431.55 85% = \$490.70
	MAXILLA, treat (Anaes.) (Assist.)	nent of fracture of, requiring open reduction and internal fixation involving plate(s)
47786	Fee: \$730.25	<b>Benefit:</b> 75% = \$547.70
	MANDIBLE, tre (Anaes.) (Assist.)	ment of fracture of, requiring open reduction and internal fixation involving plate(s)
47789	Fee: \$730.25	<b>Benefit:</b> 75% = \$547.70
		GENERAL
	BONE CYST, in	ction into or aspiration of (Anaes.)
47900	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15 85% = \$146.40
	EPICONDYLITI	, open operation for (Anaes.)
47903	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40
	DIGITAL NAIL	F TOE, removal of, not being a service to which item 47906 applies (Anaes.)
47904	Fee: \$57.40	<b>Benefit:</b> 75% = \$43.05 85% = \$48.80
	DIGITAL NAIL	F TOE, removal of, in the operating theatre of a hospital (Anaes.)
47906	Fee: \$114.65	<b>Benefit:</b> 75% = \$86.00
		FECTION, PARONYCHIA of FOOT, incision for, not being a service to which is Group applies (excluding aftercare) (Anaes.)
47912	(See para TN.8.4 o <b>Fee:</b> \$57.40	explanatory notes to this Category) <b>Benefit:</b> 75% = \$43.05 85% = \$48.80
47915	INGROWING N	IL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and

portion of the nail bed (Anaes.)  Fee: \$172.20  Benefit: 75% = \$129.15  85% = \$146.40  INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by pher electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)  47916  Fee: \$86.50  Benefit: 75% = \$64.90  85% = \$73.55  INGROWING TOENAIL, radical excision of nailbed (Anaes.)  47918  Fee: \$239.25  Benefit: 75% = \$179.45  85% = \$203.40  BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)  47920  Fee: \$386.90  Benefit: 75% = \$290.20  ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)  47921  Fee: \$114.65  Benefit: 75% = \$86.00  85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purper removal of requiring incision and suture, not being a service to which item 47927 or 47930 approached by the operating theatre of a hospital - per bone (Anaes.)  47924  Fee: \$38.25  Benefit: 75% = \$28.70  85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purper neoval of, in the operating theatre of a hospital - per bone (Anaes.)  47927  Fee: \$143.50  Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  47930  Fee: \$267.80  Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30  Benefit: 75% = \$157.75  85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A (Assist.))	PAEDIC
INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by pher electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)  Fee: \$86.50  Benefit: 75% = \$64.90  85% = \$73.55  INGROWING TOENAIL, radical excision of nailbed (Anaes.)  Fee: \$239.25  Benefit: 75% = \$179.45  85% = \$203.40  BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)  Fee: \$386.90  Benefit: 75% = \$290.20  ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)  Fee: \$114.65  Benefit: 75% = \$86.00  85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purper removal of requiring incision and suture, not being a service to which item 47927 or 47930 approached approached by the service of the particular of the purper removal of, in the operating theatre of a hospital - per bone (Anaes.)  Fee: \$143.50  Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80  Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of burisn and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30  Benefit: 75% = \$157.75  85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	
electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.)  Fee: \$86.50  Benefit: 75% = \$64.90  85% = \$73.55  INGROWING TOENAIL, radical excision of nailbed (Anaes.)  Fee: \$239.25  Benefit: 75% = \$179.45  85% = \$203.40  BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)  Fee: \$386.90  Benefit: 75% = \$290.20  ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)  Fee: \$114.65  Benefit: 75% = \$86.00  85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purpose (Anaes.)  Fee: \$38.25  Benefit: 75% = \$28.70  85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purpose (Anaes.)  Fee: \$143.50  Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80  Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of burian and any associated bursa, not being a service associated with a service removal of burian (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30  Benefit: 75% = \$157.75  85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	
INGROWING TOENAIL, radical excision of nailbed (Anaes.)  Fee: \$239.25 Benefit: 75% = \$179.45 85% = \$203.40  BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)  Fee: \$386.90 Benefit: 75% = \$290.20  ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)  Fee: \$114.65 Benefit: 75% = \$86.00 85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purpone (Anaes.)  Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purpone (Anaes.)  Fee: \$143.50 Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of burisa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	olisation,
Fee: \$239.25   Benefit: 75% = \$179.45   85% = \$203.40	
BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.)  Fee: \$386.90 Benefit: 75% = \$290.20  ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)  Fee: \$114.65 Benefit: 75% = \$86.00 85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposent of requiring incision and suture, not being a service to which item 47927 or 47930 appone (Anaes.)  Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposed of, in the operating theatre of a hospital - per bone (Anaes.)  Fee: \$143.50 Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of burisa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	
47920 Fee: \$386.90 Benefit: 75% = \$290.20  ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.)  47921 Fee: \$114.65 Benefit: 75% = \$86.00 85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposent (Anaes.)  47924 Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposent (Anaes.)  47924 Fee: \$143.50 Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  47930 Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	
Fee: \$114.65 Benefit: 75% = \$86.00 85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposence (Anaes.)  Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposence (Anaes.)  Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposence of a hospital - per bone (Anaes.)  Fee: \$143.50 Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of burian and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Assist)	
Fee: \$114.65  Benefit: 75% = \$86.00 85% = \$97.50  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposency of requiring incision and suture, not being a service to which item 47927 or 47930 approach (Anaes.)  47924  Fee: \$38.25  Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposency of, in the operating theatre of a hospital - per bone (Anaes.)  Fee: \$143.50  Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80  Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30  Benefit: 75% = \$157.75  85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Assist)	
BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposence (Anaes.)  47924 Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposence of a hospital - per bone (Anaes.)  47927 Fee: \$143.50 Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of burion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Assist)	
BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposence (Anaes.)  47924 Fee: \$38.25 Benefit: 75% = \$28.70 85% = \$32.55  BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposence of a hospital - per bone (Anaes.)  47927 Fee: \$143.50 Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of burion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Assist)	
BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purpremoval of, in the operating theatre of a hospital - per bone (Anaes.)  Fee: \$143.50  Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80  Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30  Benefit: 75% = \$157.75  85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Assist)	
removal of, in the operating theatre of a hospital - per bone (Anaes.)  Fee: \$143.50  Benefit: 75% = \$107.65  PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80  Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30  Benefit: 75% = \$157.75  85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Assist)	
PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	oses,
were inserted for internal fixation purposes, removal of, not being a service associated with a swhich item 47924 or 47927 applies - per bone (Anaes.) (Assist.)  Fee: \$267.80 Benefit: 75% = \$200.85  SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (Assist.)	
SMALL EXOSTOSIS (NOT MORE THAN 20MM OF GROWTH ABOVE BONE), excision simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	
simple removal of bunion and any associated bursa, not being a service associated with a service removal of bursa (Anaes.)  (See para TN.8.112 of explanatory notes to this Category)  Fee: \$210.30 Benefit: 75% = \$157.75 85% = \$178.80  LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	
47933 <b>Fee:</b> \$210.30 <b>Benefit:</b> 75% = \$157.75 85% = \$178.80 LARGE EXOSTOSIS (GREATER THAN 20MM GROWTH ABOVE BONE), excision of (A	
	naes.)
(See para TN.8.112 of explanatory notes to this Category) <b>Fee:</b> \$258.25 <b>Benefit:</b> 75% = \$193.70	
EXTERNAL FIXATION, removal of, in the operating theatre of a hospital (Anaes.)	
47948 <b>Fee:</b> \$162.60 <b>Benefit:</b> 75% = \$121.95	
EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation grafting or both (Anaes.)	n or bone
47951 <b>Fee:</b> \$191.20 <b>Benefit:</b> 75% = \$143.40 85% = \$162.55	
TENDON, repair of, as an independent procedure (Anaes.) (Assist.)	
47954 <b>Fee:</b> \$382.55 <b>Benefit:</b> 75% = \$286.95 85% = \$325.20	

GICAL OPERAT	IONS 15. ORTHOPAEDIC		
TENDON, large	lengthening of, as an independent procedure (Anaes.) (Assist.)		
Fee: \$286.85	<b>Benefit:</b> 75% = \$215.15		
TENOTOMY, S (Anaes.)	UBCUTANEOUS, not being a service to which another item in this Group applies		
Fee: \$133.95	<b>Benefit:</b> 75% = \$100.50 85% = \$113.90		
	PEN, with or without tenoplasty, not being a service to which another item in this anaes.)		
Fee: \$219.95	<b>Benefit:</b> 75% = \$165.00 85% = \$187.00		
TENDON OR L	IGAMENT, TRANSFER, as an independent procedure (Anaes.) (Assist.)		
Fee: \$439.90	<b>Benefit:</b> 75% = \$329.95		
TENOSYNOVE (Assist.)	CTOMY, not being a service to which another item in this Group applies (Anaes.)		
<b>Fee:</b> \$267.80	<b>Benefit:</b> 75% = \$200.85		
TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.)			
Fee: \$213.95	<b>Benefit:</b> 75% = \$160.50		
FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.)			
Fee: \$375.05	<b>Benefit:</b> 75% = \$281.30		
	CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring le and deep tissue (Anaes.)		
Fee: \$227.80	<b>Benefit:</b> 75% = \$170.85		
	LF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, ce to which another item applies (Anaes.)		
Fee: \$152.95	<b>Benefit:</b> 75% = \$114.75 85% = \$130.05		
FORAGE (Drill	decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.)		
Fee: \$370.75	<b>Benefit:</b> 75% = \$278.10		
	BONE GRAFTS		
FEMUR, bone g	raft to (Anaes.) (Assist.)		
Fee: \$765.30	<b>Benefit:</b> 75% = \$574.00		
FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.)			
Fee: \$927.85	<b>Benefit:</b> 75% = \$695.90		
TIBIA, bone gra	ft to (Anaes.) (Assist.)		
<b>Fee:</b> \$574.50	<b>Benefit:</b> 75% = \$430.90		
TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.)			
Fee: \$736.55	<b>Benefit:</b> 75% = \$552.45		
	Fee: \$286.85  TENOTOMY, S (Anaes.)  Fee: \$133.95  TENOTOMY, O Group applies (A Fee: \$219.95  TENDON OR LIFE SAME SAME SAME SAME SAME SAME SAME SAM		

T8. SUF	RGICAL OPERAT	TONS 15. ORTHOPAEDIC		
	HUMERUS, box	ne graft to (Anaes.) (Assist.)		
48212	<b>Fee:</b> \$574.50	<b>Benefit:</b> 75% = \$430.90		
	HUMERUS, box	ne graft to, with internal fixation (Anaes.) (Assist.)		
48215	Fee: \$736.55	<b>Benefit:</b> 75% = \$552.45		
40213		ULNA, bone graft to (Anaes.) (Assist.)		
40010				
48218	Fee: \$574.50	<b>Benefit:</b> 75% = \$430.90 ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)		
48221	Fee: \$765.30	<b>Benefit:</b> 75% = \$574.00		
	RADIUS OR UI	LNA, bone graft to (Anaes.) (Assist.)		
48224	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95		
	RADIUS OR UI	LNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)		
48227	Fee: \$497.40	<b>Benefit:</b> 75% = \$373.05		
	SCAPHOID, bo	ne graft to, for non-union (Anaes.) (Assist.)		
48230	Fee: \$430.55	<b>Benefit:</b> 75% = \$322.95		
		ne graft to, for non-union, with internal fixation (Anaes.) (Assist.)		
48233	<b>Fee:</b> \$621.70	<b>Benefit:</b> 75% = \$466.30		
40233		ne graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.)		
	(Assist.)			
48236	Fee: \$813.00	<b>Benefit:</b> 75% = \$609.75		
	BONE GRAFT,	not being a service to which another item in this Group applies (Anaes.) (Assist.)		
48239	Fee: \$449.55	<b>Benefit:</b> 75% = \$337.20		
10237		with internal fixation, not being a service to which another item in this Group applies		
	(Anaes.) (Assist.)			
48242	<b>Fee:</b> \$621.70	<b>Benefit:</b> 75% = \$466.30		
		OSTEOTOMY AND OSTEECTOMY		
		ETATARSAL, 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.)			
40.400				
48400	Fee: \$334.85	Benefit: 75% = \$251.15  METATARSAL astrotomy or estrectomy of with internal fivetion and avaluding		
İ	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)			
48403	Fee: \$526.10	<b>Benefit:</b> 75% = \$394.60		
10-103	-	US, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR		
	CARPUS, osteo	tomy or osteectomy of, excluding services to which items 47933 or 47936 apply		
	(Anaes.) (Assist	)		
48406	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15		

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC	
	CARPUS, osteo	US, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR tomy or osteectomy of, with internal fixation, and excluding services to which items apply (Anaes.) (Assist.)	
48409	Fee: \$526.10	<b>Benefit:</b> 75% = \$394.60	
	HUMERUS, ost (Anaes.) (Assist	eotomy or osteectomy of, excluding services to which items 47933 or 47936 apply	
48412	Fee: \$640.75	<b>Benefit:</b> 75% = \$480.60	
		eotomy or osteectomy of, with internal fixation, and excluding services to which items apply (Anaes.) (Assist.)	
48415	Fee: \$813.00	<b>Benefit:</b> 75% = \$609.75	
	TIBIA, osteoton (Assist.)	ny or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.)	
48418	<b>Fee:</b> \$640.75	<b>Benefit:</b> 75% = \$480.60	
		ny or osteectomy of, with internal fixation, and excluding services to which items 47933 Anaes.) (Assist.)	
48421	Fee: \$813.00	<b>Benefit:</b> 75% = \$609.75	
		osteotomy or osteectomy of, other than a service associated with surgery for r impingement, or to which item 47933 or 47936 applies (H) (Anaes.) (Assist.)	
48424	(See para TN.8.12 <b>Fee:</b> \$765.30	7 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$574.00	
		LVIS, osteotomy or osteectomy of, with internal fixation, and excluding services to 33 or 47936 apply (Anaes.) (Assist.)	
48427	Fee: \$927.85	<b>Benefit:</b> 75% = \$695.90	
		EPIPHYSEODESIS	
	FEMUR, epiphy	siodesis of (Anaes.) (Assist.)	
48500	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15	
	TIBIA AND FI	BULA, epiphysiodesis of (Anaes.) (Assist.)	
48503	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15	
	FEMUR, TIBIA	AND FIBULA, epiphysiodesis of (Anaes.) (Assist.)	
48506	<b>Fee:</b> \$497.40	<b>Benefit:</b> 75% = \$373.05	
		SIS, staple arrest of hemiepiphysis (Anaes.)	
48509	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45	
.020)		SIS, operation to prevent closure of plate (Anaes.) (Assist.)	
48512	<b>Fee:</b> \$908.70	<b>Benefit:</b> 75% = \$681.55	
70312	<b>Γ CC</b> • φ300.70	SHOULDER	
	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both		
48900	(Anaes.) (Assist.	*	

18. SUF	RGICAL OPERATI	ONS 15. ORTHOPAE		
	Fee: \$286.85	<b>Benefit:</b> 75% = \$215.15 85% = \$243.85		
		compression of subacromial space by acromioplasty, excision of coraco-acromial al clavicle, or any combination (Anaes.) (Assist.)		
48903	<b>Fee:</b> \$573.90	<b>Benefit:</b> 75% = \$430.45		
		pair of rotator cuff, including excision of coraco-acromial ligament or removal of rom cuff, or both - not being a service associated with a service to which item 4890 (Assist.)		
48906	<b>Fee:</b> \$573.90	<b>Benefit:</b> 75% = \$430.45		
	excision of corac	pair of rotator cuff, including decompression of subacromial space by acromioplast observation and distal clavicle, or any combination, not being a service service to which item 48903 applies (Anaes.) (Assist.)		
48909	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00		
	SHOULDER, art	hrotomy of (Anaes.) (Assist.)		
48912	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15 85% = \$284.65		
	SHOULDER, he	mi-arthroplasty of (Anaes.) (Assist.)		
48915	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00		
.0310		al replacement arthroplasty of, including any associated rotator cuff repair (Anaes.)		
48918	Fee: \$1,530.55	<b>Benefit:</b> 75% = \$1147.95		
	SHOULDER, tot	al replacement arthroplasty, revision of (Anaes.) (Assist.)		
48921	Fee: \$1,578.25	<b>Benefit:</b> 75% = \$1183.70		
	SHOULDER, tot both (Anaes.) (A	al replacement arthroplasty, revision of, requiring bone graft to scapula or humerus sist.)		
48924	Fee: \$1,817.45	<b>Benefit:</b> 75% = \$1363.10		
	SHOULDER pro	sthesis, removal of (Anaes.) (Assist.)		
48927	Fee: \$372.90	<b>Benefit:</b> 75% = \$279.70		
		bilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.		
48930	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00		
	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or			
		performed (Anaes.) (Assist.)		
48933	<b>Fee:</b> \$1,004.35	<b>Benefit:</b> 75% = \$753.30		
	SHOULDER, sy	novectomy of, as an independent procedure (Anaes.) (Assist.)		
48936	Fee: \$765.30	<b>Benefit:</b> 75% = \$574.00		
		hrodesis of, with synovectomy if performed (Anaes.) (Assist.)		
48939	Fee: \$1,100.00	<b>Benefit:</b> 75% = \$825.00		
tひフンブ	ree. \$1,100.00	Deficit. 1370 – \$023.00		

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC		
	grafting or interna	al fixation (Anaes.) (Assist.)		
	Fee: \$1,434.80	<b>Benefit:</b> 75% = \$1076.10		
		gnostic arthroscopy of (including biopsy) - not being a service associated with any e procedure of the shoulder region (Anaes.) (Assist.)		
48945	Fee: \$277.30	<b>Benefit:</b> 75% = \$208.00		
	decompression of	hroscopic surgery of, involving any 1 or more of: removal of loose bodies; calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - e associated with any other arthroscopic procedure of the shoulder region (Anaes.)		
48948	<b>Fee:</b> \$621.70	<b>Benefit:</b> 75% = \$466.30		
		hroscopic division of coraco-acromial ligament including acromioplasty - not being a l with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)		
48951	Fee: \$908.70	<b>Benefit:</b> 75% = \$681.55		
		hroscopic total synovectomy of, including release of contracture when performed - not sociated with any other arthroscopic procedure of the shoulder region (Anaes.)		
48954	Fee: \$956.50	<b>Benefit:</b> 75% = \$717.40		
	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.)			
48957	Fee: \$1,100.00	<b>Benefit:</b> 75% = \$825.00		
	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroassisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint separate approach when performed - not being a service associated with any other procedure of shoulder region (Anaes.) (Assist.)			
48960	Fee: \$956.50	<b>Benefit:</b> 75% = \$717.40		
		ELBOW		
	ELBOW, arthroto (Anaes.) (Assist.)	omy of, involving 1 or more of lavage, removal of loose body or division of contracture		
49100	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15		
	ELBOW, ligamen	ntous stabilisation of (Anaes.) (Assist.)		
49103	Fee: \$717.35	<b>Benefit:</b> 75% = \$538.05		
	ELBOW, arthrod	esis of, with synovectomy if performed (Anaes.) (Assist.)		
49106	Fee: \$956.50	<b>Benefit:</b> 75% = \$717.40 85% = \$871.80		
	ELBOW, total sy	novectomy of (Anaes.) (Assist.)		
49109	<b>Fee:</b> \$717.35	<b>Benefit:</b> 75% = \$538.05		
		or other replacement of radial head (Anaes.) (Assist.)		
49112	<b>Fee:</b> \$717.35	<b>Benefit:</b> 75% = \$538.05		
.,				

T8. SUF	RGICAL OPERATION	DNS 15. ORTHOPAEDIO
	ELBOW, total joi	nt replacement of (Anaes.) (Assist.)
49115	<b>Fee:</b> \$1,147.70	<b>Benefit:</b> 75% = \$860.80
47113	·	lacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49116	<b>Fee:</b> \$1,515.00	<b>Benefit:</b> 75% = \$1136.25
		lacement arthroplasty of, revision procedure, requiring bone grafting, including esis (Anaes.) (Assist.)
49117	Fee: \$1,818.00	<b>Benefit:</b> 75% = \$1363.50
		ic arthroscopy of, including biopsy and lavage, not being a service associated with an procedure of the elbow (Anaes.) (Assist.)
49118	<b>Fee:</b> \$277.30	<b>Benefit:</b> 75% = \$208.00
	release of contract	opic surgery involving any 1 or more of: drilling of defect, removal of loose body; ure or adhesions; chondroplasty; or osteoplasty - not being a service associated with opic procedure of the elbow (Anaes.) (Assist.)
49121	<b>Fee:</b> \$621.70	<b>Benefit:</b> 75% = \$466.30
		WRIST
		is of, with synovectomy if performed, with or without bone graft and internal fixation joint (Anaes.) (Assist.)
49200	(See para TN.8.116 <b>Fee:</b> \$832.05	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$624.05
	WRIST, limited a bone graft (Anaes	throdesis of the intercarpal joint, with synovectomy if performed, with or without ) (Assist.)
49203	(See para TN.8.116 <b>Fee:</b> \$621.70	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$466.30
	WRIST, proximal	carpectomy of, including styloidectomy when performed (Anaes.) (Assist.)
49206	(See para TN.8.116 <b>Fee:</b> \$573.90	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$430.45
	WRIST, total repl	acement arthroplasty of (Anaes.) (Assist.)
49209	(See para TN.8.116 <b>Fee:</b> \$765.30	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$574.00
	WRIST, total repl (Assist.)	acement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49210	Fee: \$1,010.20	<b>Benefit:</b> 75% = \$757.65
		acement arthroplasty of, revision procedure, requiring bone grafting, including esis (Anaes.) (Assist.)
49211	Fee: \$1,212.25	<b>Benefit:</b> 75% = \$909.20
	WRIST, arthroton	y of (Anaes.)
49212	(See para TN.8.116 <b>Fee:</b> \$239.25	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$179.45

WRIST, reconstruction of, including repair of single or multipassociated arthrotomy (Anaes.) (Assist.)	ple ligaments or capsules, including
associated artifictionly (Pilacs.) (Pissist.)	
(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$660.10 <b>Benefit:</b> 75% = \$495.10	
WRIST, diagnostic arthroscopy of, including radiocarpal or meant to being a service associated with any other arthroscopic preference.	
(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$277.30 <b>Benefit:</b> 75% = \$208.00	
WRIST, arthroscopic surgery of, involving any 1 or more of: release of adhesions; local synovectomy; or debridement of or with any other arthroscopic procedure of the wrist joint (Anae	ne area - not being a service associated
(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$621.70 <b>Benefit:</b> 75% = \$466.30	
WRIST, arthroscopic debridement of 2 or more distinct areas; distal ulna; or total synovectomy, not being a service associate the wrist (Anaes.) (Assist.)	
(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$717.35 <b>Benefit:</b> 75% = \$538.05	
WRIST, arthroscopic pinning of osteochondral fragment or stadisruption - not being a service associated with any other arthrograms.) (Assist.)	
(See para TN.8.116 of explanatory notes to this Category) <b>Fee:</b> \$717.35 <b>Benefit:</b> 75% = \$538.05	
HIP	
SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.)	
<b>Fee:</b> \$529.60 <b>Benefit:</b> 75% = \$397.20	
Hip, arthrotomy of, including lavage, drainage or biopsy when associated with surgery for femoroacetabular impingement (H	
(See para TN.8.127 of explanatory notes to this Category) <b>Fee:</b> \$554.75 <b>Benefit:</b> 75% = \$416.10	
HIP arthrodesis of, with synovectomy if performed (Anaes.)	(Assist.)
<b>Fee:</b> \$1,100.00 <b>Benefit:</b> 75% = \$825.00	
HIP, arthrectomy or excision arthroplasty of, including remov (non cement )) (Anaes.) (Assist.)	al of prosthesis (Austin Moore or similar
<b>Fee:</b> \$765.30 <b>Benefit:</b> 75% = \$574.00	
HIP, arthrectomy or excision arthroplasty of, including remov or similar) (Anaes.) (Assist.)	al of prosthesis (cemented, porous coated
<b>Fee:</b> \$956.50 <b>Benefit:</b> 75% = \$717.40	
HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.)	
<b>Fee:</b> \$860.90 <b>Benefit:</b> 75% = \$645.70	
	Fee: \$660.10   Benefit: 75% = \$495.10

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
	HIP, total replace	ment arthroplasty of, including minor bone grafting (Anaes.) (Assist.)
49318	<b>Fee:</b> \$1,338.90	<b>Benefit:</b> 75% = \$1004.20
.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	·	ment arthroplasty of, including associated minor grafting, if performed - bilateral
49319	Fee: \$2,352.35	<b>Benefit:</b> 75% = \$1764.30
	HIP, total replace (Anaes.) (Assist.)	ment arthroplasty of, including major bone grafting, including obtaining of graft
49321	Fee: \$1,626.25	<b>Benefit:</b> 75% = \$1219.70
	HIP, total replace (Assist.)	ment arthroplasty of, revision procedure including removal of prosthesis (Anaes.)
49324	Fee: \$1,913.10	<b>Benefit:</b> 75% = \$1434.85
		ment arthroplasty of, revision procedure requiring bone grafting to acetabulum, ng of graft (Anaes.) (Assist.)
49327	Fee: \$2,200.00	<b>Benefit:</b> 75% = \$1650.00
	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, incobtaining of graft (Anaes.) (Assist.)	
49330	Fee: \$2,200.00	<b>Benefit:</b> 75% = \$1650.00
	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.)	
49333	Fee: \$2,487.00	<b>Benefit:</b> 75% = \$1865.25
	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of treatment of the fracture (not including intra-operative fracture), being a service associated with a to which items 49324 to 49333 apply (Anaes.) (Assist.)	
49336	Fee: \$363.40	<b>Benefit:</b> 75% = \$272.55
	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than cm in length (Anaes.) (Assist.)	
49339	<b>Fee:</b> \$2,821.75	<b>Benefit:</b> 75% = \$2116.35
	HIP, revision tota	l replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.)
49342	Fee: \$2,821.75	<b>Benefit:</b> 75% = \$2116.35
	HIP, revision tota (Anaes.) (Assist.)	l replacement of, requiring anatomic specific allograft of both femur and acetabulum
49345	<b>Fee:</b> \$3,347.80	<b>Benefit:</b> 75% = \$2510.85
	HIP, revision arth	roplasty with replacement of acetabular liner or ceramic head, not requiring removal of nt or acetabular shell (Anaes.) (Assist.)
49346	Fee: \$860.90	<b>Benefit:</b> 75% = \$645.70
	HIP, diagnostic at the hip (Anaes.) (	rthroscopy of, not being a service associated with any other arthroscopic procedure of Assist.)
49360	<b>Fee:</b> \$349.45	<b>Benefit:</b> 75% = \$262.10

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC
		rthroscopy of, with synovial biopsy, not being a service associated with any other edure of the hip (Anaes.) (Assist.)
49363	Fee: \$420.85	<b>Benefit:</b> 75% = \$315.65 85% = \$357.75
		surgery of, other than a service associated with another arthroscopic procedure of the associated with surgery for femoroacetabular impingement (H) (Anaes.) (Assist.)
49366	(See para TN.8.127 <b>Fee:</b> \$621.70	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$466.30
		KNEE
		y of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose ody (Anaes.) (Assist.)
49500	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95
	chondroplasty of	total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not which another item in this Group applies) - any 1 procedure (Anaes.) (Assist.)
49503	Fee: \$497.40	<b>Benefit:</b> 75% = \$373.05
	chondroplasty of	total meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, osteoplasty of, patellofemoral stabilisation or single transfer of ligament or tendon (not which another item in this Group applies) - any 2 or more procedures (Anaes.)
49506	Fee: \$746.15	<b>Benefit:</b> 75% = \$559.65
	KNEE, total sync	vectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.)
49509	Fee: \$765.30	<b>Benefit:</b> 75% = \$574.00
	KNEE, arthrodes	is of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.)
49512	Fee: \$1,100.00	<b>Benefit:</b> 75% = \$825.00
		of prosthesis, cemented or uncemented, including associated cement, as the first stage dure (Anaes.) (Assist.)
49515	Fee: \$860.90	<b>Benefit:</b> 75% = \$645.70
	KNEE, hemiarthi	roplasty of (Anaes.) (Assist.)
49517	Fee: \$1,225.65	<b>Benefit:</b> 75% = \$919.25
		acement arthroplasty of (Anaes.) (Assist.)
49518	Fee: \$1,338.90	<b>Benefit:</b> 75% = \$1004.20
	KNEE, total replacement (Anaes.) (Assist.)	acement arthroplasty of, including associated minor grafting, if performed - bilateral
49519	Fee: \$2,352.35	<b>Benefit:</b> 75% = \$1764.30
	_	acement arthroplasty of, requiring major bone grafting to femur or tibia, including (Anaes.) (Assist.)
49521	Fee: \$1,626.25	<b>Benefit:</b> 75% = \$1219.70
49524	KNEE, total repla	acement arthroplasty of, requiring major bone grafting to femur and tibia, including

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC
	obtaining of graft	t (Anaes.) (Assist.)
	Fee: \$1,913.10	<b>Benefit:</b> 75% = \$1434.85
	KNEE, total repla (Assist.)	acement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49527	Fee: \$1,626.25	<b>Benefit:</b> 75% = \$1219.70
		accement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, ng of graft and including removal of prosthesis (Anaes.) (Assist.)
49530	Fee: \$2,008.85	<b>Benefit:</b> 75% = \$1506.65
		accement arthroplasty of, revision procedure, requiring bone grafting to both femur and btaining of graft and including removal of prosthesis (Anaes.) (Assist.)
49533	Fee: \$2,295.80	<b>Benefit:</b> 75% = \$1721.85
	KNEE, patello-fe	emoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.)
49534	Fee: \$456.75	<b>Benefit:</b> 75% = \$342.60
	cruciate or collate	reconstruction of, for chronic instability (open or arthroscopic, or both) involving either eral ligaments, including notchplasty when performed, not being a service associated throscopic procedure of the knee (Anaes.) (Assist.)
49536	Fee: \$956.50	<b>Benefit:</b> 75% = \$717.40
	including notchpl	ctive surgery of cruciate ligament or ligaments (open or arthroscopic, or both), lasty when performed and surgery to other internal derangements, not being a service to m in this Group applies or a service associated with any other arthroscopic procedure es.) (Assist.)
49539	Fee: \$956.50	<b>Benefit:</b> 75% = \$717.40
	including notchpl	ctive surgery to cruciate ligament or ligaments (open or arthroscopic, or both), lasty, meniscus repair, extracapsular procedure and debridement when performed, not ssociated with any other arthroscopic procedure of the knee (Anaes.) (Assist.)
49542	Fee: \$1,338.90	<b>Benefit:</b> 75% = \$1004.20
	KNEE, revision a	arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
49545	Fee: \$765.30	<b>Benefit:</b> 75% = \$574.00
	KNEE, revision of	of patello-femoral stabilisation (Anaes.) (Assist.)
49548	Fee: \$956.50	<b>Benefit:</b> 75% = \$717.40
	KNEE, revision of	of procedures to which item 49536, 49539 or 49542 applies (Anaes.) (Assist.)
49551	Fee: \$1,338.90	<b>Benefit:</b> 75% = \$1004.20
	KNEE, revision of (Assist.)	of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.)
49554	Fee: \$1,913.10	<b>Benefit:</b> 75% = \$1434.85
49557	being a service as	c arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not essociated with autologous chondrocyte implantation or matrix-induced autologous lantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATION	ONS	15. ORTHOPAEDIC
	(See para TN.8.117 <b>Fee:</b> \$277.30	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$208.00	
		oic surgery of, involving 1 or more of: debridement, ostory other arthroscopic procedure of the knee region (Ana	
49558	<b>Fee:</b> \$277.30	<b>Benefit:</b> 75% = \$208.00	
	similar) implant; i	oic surgery of, involving chondroplasty requiring multipulating any associated debridement or oestoplasty - needure of the knee region (Anaes.) (Assist.)	
49559	Fee: \$415.25	<b>Benefit:</b> 75% = \$311.45	
		oic surgery of, involving 1 or more of: partial or total mease - not being a service associated with any other arthassist.)	
49560	Fee: \$560.45	<b>Benefit:</b> 75% = \$420.35	
	removal of loose b	SCOPIC SURGERY OF, involving 1 or more of: partial pody or lateral release; where the procedure includes as androplasty - not associated with any other arthroscopic	sociated debridement,
49561	Fee: \$684.80	<b>Benefit:</b> 75% = \$513.60	
	removal of loose be drilling or carbon	SCOPIC SURGERY OF, involving 1 or more of: partial pody or lateral release; where the procedure includes charge (or similar) implant and associated debridement of the knee region (Anaes.) (Assist	ondroplasty requiring multiple r osteoplasty - not associated
49562	Fee: \$747.25	<b>Benefit:</b> 75% = \$560.45	
	chondral graft (ex	oic surgery of, involving 1 or more of: meniscus repair; cluding autologous chondrocyte implantation or matrix antation) -not associated with any other arthroscopic pro-	-induced autologous
49563	(See para TN.8.117 <b>Fee:</b> \$809.45	of explanatory notes to this Category) <b>Benefit:</b> 75% = \$607.10	
	release, medial ca	moral stabilisation of, combined arthroscopic and open psulorrhaphy and tendon transfer, not being a service as edure of the knee (Anaes.) (Assist.)	
49564	Fee: \$933.75	<b>Benefit:</b> 75% = \$700.35	
		oic total synovectomy of, not being a service associated nee (Anaes.) (Assist.)	with any other arthroscopic
49566	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00	
	KNEE, mobilisati (Anaes.) (Assist.)	on for post-traumatic stiffness, by multiple muscle or te	endon release (quadricepsplasty)
49569	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00	
		ANKLE	
49700	ANKLE, diagnost	ic arthroscopy of, including biopsy (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERAT	ONS 15. ORTHO	OPAEDIC .	
	<b>Fee:</b> \$277.30	<b>Benefit:</b> 75% = \$208.00		
	ANKLE, arthros of the ankle (Ana	copic surgery of, not being a service associated with any other arthroscopic praes.) (Assist.)	ocedure	
49703	<b>Fee:</b> \$621.70	<b>Benefit:</b> 75% = \$466.30		
	ANKLE, arthroto (Anaes.) (Assist.	omy of, involving 1 or more of: lavage, removal of loose body or division of c	ontracture	
49706	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15		
	ANKLE, ligame	ntous stabilisation of (Anaes.) (Assist.)		
49709	<b>Fee:</b> \$717.35	<b>Benefit:</b> 75% = \$538.05		
	ANKLE, arthrod	esis of, with synovectomy if performed (Anaes.) (Assist.)		
49712	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00		
	ANKLE, total jo	int replacement of (Anaes.) (Assist.)		
49715	<b>Fee:</b> \$1,147.70	<b>Benefit:</b> 75% = \$860.80		
		placement arthroplasty of, revision procedure, including removal of prosthesis	(Anaes.)	
49716	Fee: \$1,515.00	<b>Benefit:</b> 75% = \$1136.25		
		placement arthroplasty of, revision procedure, requiring bone grafting, includinesis (Anaes.) (Assist.)	ng	
49717	Fee: \$1,818.00	<b>Benefit:</b> 75% = \$1363.50		
	ANKLE, Achille	s' tendon or other major tendon, repair of (Anaes.) (Assist.)		
49718	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95		
	ANKLE, Achille	s' tendon rupture managed by non-operative treatment		
49721	Fee: \$239.25	<b>Benefit:</b> 75% = \$179.45 85% = \$203.40		
	ANKLE, Achille	s' tendon, secondary repair or reconstruction of (Anaes.) (Assist.)		
49724	<b>Fee:</b> \$669.70	<b>Benefit:</b> 75% = \$502.30		
	ANKLE, Achille	s' tendon, operation for lengthening (Anaes.) (Assist.)		
49727	Fee: \$286.85	<b>Benefit:</b> 75% = \$215.15		
	ANKLE, lengthening of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus deformity in children with cerebral palsy (Anaes.) (Assist.)		equinus	
49728	Fee: \$573.75	<b>Benefit:</b> 75% = \$430.35		
		FOOT		
	FOOT, flexor or extensor tendon, primary repair of (Anaes.)			
49800	Fee: \$133.95	<b>Benefit:</b> 75% = \$100.50 85% = \$113.90		
	FOOT, flexor or	extensor tendon, secondary repair of (Anaes.)		
49803	Fee: \$172.20	<b>Benefit:</b> 75% = \$129.15 85% = \$146.40		

T8. SUF	RGICAL OPERAT	IONS 15. ORT	THOPAEDIC
	FOOT, subcutan	eous tenotomy of, 1 or more tendons (Anaes.)	
49806	Fee: \$133.95	<b>Benefit:</b> 75% = \$100.50 85% = \$113.90	
	FOOT, open tene	otomy of, with or without tenoplasty (Anaes.)	
49809	Fee: \$219.95	<b>Benefit:</b> 75% = \$165.00	
	FOOT, tendon of applies (Anaes.)	r ligament transplantation of, not being a service to which another item in the (Assist.)	his Group
49812	<b>Fee:</b> \$439.90	<b>Benefit:</b> 75% = \$329.95	
	FOOT, triple artl	hrodesis of, with synovectomy if performed (Anaes.) (Assist.)	
49815	<b>Fee:</b> \$765.30	<b>Benefit:</b> 75% = \$574.00	
	FOOT, excision	of calcaneal spur (Anaes.) (Assist.)	
49818	Fee: \$277.30	<b>Benefit:</b> 75% = \$208.00	
	· ·	n of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or sin ateral (Anaes.) (Assist.)	nilar
49821	<b>Fee:</b> \$439.90	<b>Benefit:</b> 75% = \$329.95	
		n of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or sinteral (Anaes.) (Assist.)	nilar
49824	<b>Fee:</b> \$770.10	<b>Benefit:</b> 75% = \$577.60	
	FOOT, correctio	n of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anac	es.) (Assist.)
49827	Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70	
	FOOT, correctio	n of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes	s.) (Assist.)
49830	Fee: \$836.95	<b>Benefit:</b> 75% = \$627.75	
		n of hallux valgus by osteotomy of first metatarsal with or without internal excision of exostoses associated with the first metatarsophalangeal joint - u )	
49833	Fee: \$526.10	<b>Benefit:</b> 75% = \$394.60	
		n of hallux valgus by osteotomy of first metatarsal with or without internal excision of exostoses associated with the first metatarsophalangeal joint - b	
49836	<b>Fee:</b> \$908.70	<b>Benefit:</b> 75% = \$681.55	
	tendon, with or v	n of hallux valgus by osteotomy of first metatarsal and transfer of adductor without internal fixation and with or without excision of exostoses associated alangeal joint - unilateral (Anaes.) (Assist.)	
49837	Fee: \$657.60	<b>Benefit:</b> 75% = \$493.20	
	tendon, with or v	n of hallux valgus by osteotomy of first metatarsal and transfer of adductor without internal fixation and with or without excision of exostoses associated alangeal joint - bilateral (Anaes.) (Assist.)	
49838	Fee: \$1,135.65	<b>Benefit:</b> 75% = \$851.75	
49839	FOOT, correctio	n of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (A	Anaes.)

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	(Assist.)	
	Fee: \$526.10	<b>Benefit:</b> 75% = \$394.60
	FOOT, correctio (Assist.)	n of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.)
49842	<b>Fee:</b> \$908.70	<b>Benefit:</b> 75% = \$681.55
	FOOT, arthrodes	sis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.)
49845	Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70
	FOOT, correctio	n of claw or hammer toe (Anaes.)
49848	Fee: \$162.60	<b>Benefit:</b> 75% = \$121.95 85% = \$138.25
	FOOT, correctio	n of claw or hammer toe with internal fixation (Anaes.)
49851	Fee: \$210.30	<b>Benefit:</b> 75% = \$157.75
1,7001		lantar fasciotomy or fasciectomy of (Anaes.) (Assist.)
49854	Fee: \$382.55	<b>Benefit:</b> 75% = \$286.95
47034		p-phalangeal joint replacement (Anaes.) (Assist.)
40057		
49857	FOOT synovect	<b>Benefit:</b> 75% = \$265.45 omy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)
49860	Fee: \$286.85	<b>Benefit:</b> 75% = \$215.15
	FOO1, synovect	omy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)
49863	Fee: \$430.55	<b>Benefit:</b> 75% = \$322.95
	FOOT, neurector	my for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)
49866	Fee: \$305.85	<b>Benefit:</b> 75% = \$229.40
	-	NOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or ach attendance (Anaes.)
49878	<b>Fee:</b> \$57.40	<b>Benefit:</b> 75% = \$43.05 85% = \$48.80
		OTHER JOINTS
		ic arthroscopy of (including biopsy), not being a service to which another item in this and not being a service associated with any other arthroscopic procedure (Anaes.)
50100	Fee: \$277.30	<b>Benefit:</b> 75% = \$208.00 85% = \$235.75
	JOINT, arthrosco (Assist.)	opic surgery of, not being a service to which another item in this Group applies (Anaes.)
50102	Fee: \$621.70	<b>Benefit:</b> 75% = \$466.30
	JOINT, arthrotor	my of, not being a service to which another item in this Group applies (Anaes.) (Assist.)
50103	Fee: \$334.85	<b>Benefit:</b> 75% = \$251.15
50104		tomy of, not being a service to which another item in this Group applies (Anaes.)

T8. SUF	RGICAL OPERAT	TIONS 15. ORTHOPAEDIC
	(Assist.)	
	<b>Fee:</b> \$317.30	<b>Benefit:</b> 75% = \$238.00 85% = \$269.75
		tion of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, ice to which another item in this Group applies (Anaes.) (Assist.)
50106	Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70
		esis of, not being a service to which another item in this Group applies, with performed (Anaes.) (Assist.)
50109	Fee: \$478.25	<b>Benefit:</b> 75% = \$358.70
		FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving an skin and subcutaneous tissue, not being a service to which another item in this Group (Assist.)
50112	Fee: \$366.85	<b>Benefit:</b> 75% = \$275.15
		TS, manipulation of, performed in the operating theatre of a hospital, not being a service a service to which another item in this Group applies (Anaes.)
50115	Fee: \$145.25	<b>Benefit:</b> 75% = \$108.95
	SUBTALAR JO	DINT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
50118	Fee: \$439.90	<b>Benefit:</b> 75% = \$329.95
	GREATER TRO	OCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.)
50121	Fee: \$860.90	<b>Benefit:</b> 75% = \$645.70
	JOINT OR JOIN (Anaes.) (Assist	NTS, arthroplasty of, by any technique not being a service to which another item applies .)
50127	Fee: \$713.75	<b>Benefit:</b> 75% = \$535.35
	JOINT OR JOIN (Assist.)	NTS, application of external fixator to, other than for treatment of fractures (Anaes.)
50130	<b>Fee:</b> \$317.30	<b>Benefit:</b> 75% = \$238.00
		MALIGNANT DISEASE
		OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, acluding aftercare) (Anaes.)
50200	Fee: \$191.20	<b>Benefit:</b> 75% = \$143.40 85% = \$162.55
		OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, vascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.)
50201	Fee: \$334.75	<b>Benefit:</b> 75% = \$251.10
	BONE OR MAI (Assist.)	LIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.)
50203	Fee: \$420.90	<b>Benefit:</b> 75% = \$315.70 85% = \$357.80
		JR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, aft or cementation (Anaes.) (Assist.)
ı		<b>Benefit:</b> 75% = \$466.30

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
		, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen , allograft or cementation (Anaes.) (Assist.)
50209	Fee: \$765.30	<b>Benefit:</b> 75% = \$574.00
		AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, f, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.)
50212	Fee: \$1,673.90	<b>Benefit:</b> 75% = \$1255.45
	enbloc resection o	AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, f, with compartmental or wide excision of soft tissue, with intercalary reconstruction aft or autograft) (Anaes.) (Assist.)
50215	<b>Fee:</b> \$2,104.35	<b>Benefit:</b> 75% = \$1578.30
		JMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of h synovectomy if performed (Anaes.) (Assist.)
50218	Fee: \$2,774.00	<b>Benefit:</b> 75% = \$2080.50
		AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or HOULDER, enbloc resection of (Anaes.) (Assist.)
50221	Fee: \$2,582.50	<b>Benefit:</b> 75% = \$1936.90
		AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or HOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or (Assist.)
50224	Fee: \$2,869.55	<b>Benefit:</b> 75% = \$2152.20 85% = \$2784.85
		ONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or without prosthetic replacement (Anaes.) (Assist.)
50227	Fee: \$3,347.80	<b>Benefit:</b> 75% = \$2510.85
	BENIGN TUMO (Anaes.) (Assist.)	JR, resection of, requiring anatomic specific allograft, with or without internal fixation
50230	<b>Fee:</b> \$1,721.70	<b>Benefit:</b> 75% = \$1291.30
	MALIGNANT TU	JMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.)
50233	Fee: \$2,200.00	<b>Benefit:</b> 75% = \$1650.00
	MALIGNANT TU femur (Anaes.) (A	JMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third ssist.)
50236	<b>Fee:</b> \$1,721.70	<b>Benefit:</b> 75% = \$1291.30
	MALIGNANT TU applies (Anaes.) (	JMOUR, amputation for, not being a service to which another item in this Group Assist.)
50239	<b>Fee:</b> \$1,147.70	<b>Benefit:</b> 75% = \$860.80
		LIMB LENGTHENING AND DEFORMITY CORRECTION
		ITY, slow correction of, using ring fixator or similar device, including all associated able only once in any 12 month period (Anaes.) (Assist.)
50300	Fee: \$1,176.20	<b>Benefit:</b> 75% = \$882.15

n of an external fixator or once per limb in any 12  t is performed or where the tening is greater than 5cm  sertion or removal of a hospital, not being a sertion or arthroscopic
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Assist.)
rocedure (Anaes.) (Assist.)
rocedure (Anaes.) (Assist.)
nipulation and change of spital, not being a service to
r similar graft (Anaes.)
onstruction (Anaes.)
ral column (Anaes.)

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOP	AEDIC
		KLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrior aspect of foot (Anaes.) (Assist.)	rane to
50342	Fee: \$662.05	<b>Benefit:</b> 75% = \$496.55	
		SION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthen and release of capsule contracture (Anaes.) (Assist.)	ing of
50345	Fee: \$352.20	<b>Benefit:</b> 75% = \$264.15	
		HIP, KNEE AND LEG PROCEDURES	
		y of, post-operative manipulation and change of plaster, performed under general the operating theatre of a hospital (Anaes.)	
50348	Fee: \$232.35	<b>Benefit:</b> 75% = \$174.30	
	HIP, congenital	lislocation of, treatment of, by closed reduction (Anaes.)	
50349	Fee: \$325.25	<b>Benefit:</b> 75% = \$243.95 85% = \$276.50	
	HIP, developme	ntal dislocation of, open reduction of (Anaes.) (Assist.)	
50351	Fee: \$1,622.80	<b>Benefit:</b> 75% = \$1217.10	
	HIP, congenital attendance (Ana	dislocation of, treatment of, involving supervision of splint, harness or cast - each es.)	
50352	Fee: \$57.40	<b>Benefit:</b> 75% = \$43.05 85% = \$48.80	
	HIP SPICA, init (Assist.)	al application of, for congenital dislocation of hip (excluding aftercare) (Anaes.)	
50353	Fee: \$360.50	<b>Benefit:</b> 75% = \$270.40	
	TIBIA, pseudart	prosis of, congenital, resection and internal fixation (Anaes.) (Assist.)	
50354	<b>Fee:</b> \$1,331.10	<b>Benefit:</b> 75% = \$998.35 85% = \$1246.40	
	KNEE, LEG OR (Anaes.) (Assist.	THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon tra	nsfer
50357	Fee: \$570.55	<b>Benefit:</b> 75% = \$427.95	
	KNEE, LEG OR	THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist	.)
50360	Fee: \$662.05	<b>Benefit:</b> 75% = \$496.55	
	KNEE, contracto (Anaes.) (Assist.	re of, posterior release involving multiple tendon lengthening or tenotomies, uni	lateral
50363	Fee: \$507.05	<b>Benefit:</b> 75% = \$380.30	
	KNEE, contracto (Anaes.) (Assist.	re of, posterior release involving multiple tendon lengthening or tenotomies, bilated)	teral
50366	Fee: \$887.45	<b>Benefit:</b> 75% = \$665.60	
50369		are of, posterior release involving multiple tendon lengthening with or without elease of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assert	sist.)

	ONS 15. ORTHOPAE	DIC
Fee: \$662.05	<b>Benefit:</b> 75% = \$496.55	
		)
Fee: \$1,162.10	<b>Benefit:</b> 75% = \$871.60	
		with
Fee: \$507.05	<b>Benefit:</b> 75% = \$380.30	
		with
Fee: \$887.45	<b>Benefit:</b> 75% = \$665.60	
		ıS
Fee: \$662.05	<b>Benefit:</b> 75% = \$496.55	
		ıs
Fee: \$1,162.10	<b>Benefit:</b> 75% = \$871.60	
HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greate trochanter, or transfer of adductors to ischium (Anaes.) (Assist.)		
Fee: \$662.05	<b>Benefit:</b> 75% = \$496.55	
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: \$232.35	<b>Benefit:</b> 75% = \$174.30	
PELVIS, bone gr	aft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.)	
<b>Fee:</b> \$859.15	<b>Benefit:</b> 75% = \$644.40	
ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.)		ıal
<b>Fee:</b> \$2,821.75	<b>Benefit:</b> 75% = \$2116.35	
	SHOULDER, ARM AND FOREARM PROCEDURES	
Fee: \$472.00	<b>Benefit:</b> 75% = \$354.00	
		ı of
Fee: \$936.80	<b>Benefit:</b> 75% = \$702.60	
TORTICOLLIS, (Assist.)	pipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.)	
	KNEE, contracture tenotomies and re  Fee: \$1,162.10  HIP, contracture of or without division  Fee: \$507.05  HIP, contracture of or without division  Fee: \$887.45  HIP, contracture of with or without division  Fee: \$662.05  HIP, contracture of with or without division  Fee: \$662.05  HIP, contracture of with or without division  Fee: \$662.05  PERTHES, CERE application of case polication of case polication of case polication where per fee: \$232.35  PELVIS, bone gray from the per fee: \$2,821.75  HAND, congenitary phalanges, with light fee: \$472.00  FOREARM, RAE (Anaes.) (Assist.)  Fee: \$936.80  TORTICOLLIS, 80	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: \$1,162.10

T8. SUF	RGICAL OPERAT	ions	15. ORTHOPAEDIC
	Fee: \$429.70	<b>Benefit:</b> 75% = \$322.30	
	ELBOW, flexorp	plasty, or tendon transfer to restore el	pow function (Anaes.) (Assist.)
50405	Fee: \$584.60	<b>Benefit:</b> 75% = \$438.45	
	SHOULDER, co	ngenital or developmental dislocation	n, open reduction of (Anaes.) (Assist.)
50408	Fee: \$1,014.20	<b>Benefit:</b> 75% = \$760.65	
			CONGENITAL DEFORMITIES LOWER LIMB of the femur by resection of the distal femur and ee fusion (Anaes.) (Assist.)
50411	Fee: \$1,331.10	<b>Benefit:</b> 75% = \$998.35 85% = \$	1246.40
		DEFICIENCY, treatment of congenit nal tibia followed by knee fusion and	al deficiency of the femur by resection of the distal rotationplasty (Anaes.) (Assist.)
50414	Fee: \$1,795.90	<b>Benefit:</b> 75% = \$1346.95 85% =	\$1711.20
	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.)		
50417	Fee: \$1,331.10	<b>Benefit:</b> 75% = \$998.35 85% = \$	1246.40
	PATELLA, cong	genital dislocation of, reconstruction	of the quadriceps (Anaes.) (Assist.)
50420	Fee: \$1,098.65	<b>Benefit:</b> 75% = \$824.00	
	TIBIA, FIBULA fixation (Anaes.)	•	, transfer of the fibula to tibia, with internal
50423	Fee: \$1,014.20	<b>Benefit:</b> 75% = \$760.65 85% = \$	929.50
		TUMOROUS C	ONDITIONS
	DIAPHYSEAL .	ACLASIA, removal of lesion or lesion	ns from bone - 1 approach (Anaes.) (Assist.)
50426	Fee: \$472.00	<b>Benefit:</b> 75% = \$354.00	
	SINGL	E EVEN MULTILEVEL SURGERY FO	OR CHILDREN WITH CEREBRAL PALSY
		SINGLE EVENT MULTILEVEL SU oral palsy comprising three or more o	URGERY for patients less than 18 years of age with f the following:
	` '	g of one or more contracted muscle to actional lengthening or intramuscular	endon units by tendon lengthening, muscle lengthening.
	(b) Correction	of muscle imbalance by tendon trans	Fer/transfers.
	(c) Correction	of femoral torsion by rotational osteo	tomy of the femur.
	(d) Correction	of tibial torsion by rotational osteoto	ny of the tibia.
		of joint instability by varus derotation y if performed, or os calcis lengtheni	n osteotomy of the femur, subtalar arthrodesis, with ng.
50450	Conjoint surgery	, principal specialist surgeon, includi	ng fluoroscopy and aftercare (Anaes.) (Assist.)

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,246.55 <b>Benefit:</b> 75% = \$934.95	
	UNILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients les hemiplegic cerebral palsy comprising three or more of the following:	s than 18 years of age with
	(a) Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	ngthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of femoral torsion by rotational osteotomy of the femur.	
	(d) Correction of tibial torsion by rotational osteotomy of the tibia.	
	(e) Correction of joint instability by varus derotation osteotomy of the femus synovectomy if performed, or os calcis lengthening.	r, subtalar arthrodesis, with
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclu(Assist.)	iding aftercare (Anaes.)
50451	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,246.55 <b>Benefit:</b> 75% = \$934.95	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises:	than 18 years of age with
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening or intramuscular lengthening.	ngthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and after	care (Anaes.) (Assist.)
50455	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,411.65 <b>Benefit:</b> 75% = \$1058.75	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises:	than 18 years of age with
	(a) Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	ngthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclu(Assist.)	iding aftercare (Anaes.)
50456	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,411.65 <b>Benefit:</b> 75% = \$1058.75	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral	
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening or intramuscular lengthening.	ngthening, muscle
50460	(`) Correction of muscle imbalance by tendon transfer/transfers.	

T8. SURG	GICAL OPERATIONS 15. ORTHOPAEDIC
	( ) 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 TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,107.65 <b>Benefit:</b> 75% = \$1580.75
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral femoral osteotomies.
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(b) Correction of muscle imbalance by tendon transfer/transfers.
	(c) Correction of torsional abnormality of the femur by rotational osteotomy and internal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)
50461	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,107.65 <b>Benefit:</b> 75% = \$1580.75
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	( ) Correction of muscle imbalance by tendon transfer/transfers.
	( ) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.
	(`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
50465	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,968.55 <b>Benefit:</b> 75% = \$2226.45
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.
	(a) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(b) Correction of muscle imbalance by tendon transfer/transfers.
	(c) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.
	(d) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftercare (Anaes.) (Assist.)
50466	(See para TN.8.118 of explanatory notes to this Category)

T8. SUR	GICAL OPERATIONS	15. ORTHOPAEDIC
	<b>Fee:</b> \$2,968.55 <b>Benefit:</b> 75% = \$2226.45	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral os osteotomies and bilateral foot stabilisation.	
	(`) Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	engthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(`) Correction of abnormal torsion of the femur by rotational osteotomy with	th 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 fu	sion.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and after	ercare (Anaes.) (Assist.)
50470	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,764.85 <b>Benefit:</b> 75% = \$2823.65	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral os osteotomies and bilateral foot stabilisation.	
	(a) Lengthening of one or more contracted muscle tendon units by tendon l recession, fractional lengthening or intramuscular lengthening.	engthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of abnormal torsion of the femur by rotational osteotomy wi	th internal fixation.
	(d) Correction of abnormal torsion of the tibia by rotational osteotomy with	n internal fixation.
	(e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fu	usion.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and exclassist.)	luding aftercare (Anaes.)
50471	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,764.85 <b>Benefit:</b> 75% = \$2823.65	
	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years cerebral palsy for the correction of crouch gait including:	of age with diplegic
	(`) Lengthening of one or more contracted muscle tendon units by tendon le recession, fractional lengthening or intramuscular lengthening.	engthening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(`) Correction of flexion deformity at the knee by extension osteotomy of the internal fixation.	he distal femur including
	(`) Correction of patella alta and quadriceps insufficiency by patella tendon	shortening/reconstruction.
50475	(`) Correction of tibial torsion by rotational osteotomy of the tibia with inte	rnal fixation.

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	(`) Correction of foot instability by os calcis lengthening or subtalar fusion.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,344.25 <b>Benefit:</b> 75% = \$3258.20
	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.)
50476	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,344.25 <b>Benefit:</b> 75% = \$3258.20
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS
	RADIUS OR ULNA, distal end of, with open growth plate, treatment of fracture of, by closed reduction (Anaes.)
50500	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$281.10 <b>Benefit:</b> 75% = \$210.85 85% = \$238.95
	RADIUS OR ULNA, distal end of, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)
50504	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$374.95 <b>Benefit:</b> 75% = \$281.25  85% = \$318.75
	RADIUS, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.)
50508	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$401.55 <b>Benefit:</b> 75% = \$301.20 85% = \$341.35
	RADIUS, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.)
50512	(See para TN.8.119, TN.8.118 of explanatory notes to this Category)  Fee: \$535.75  Benefit: 75% = \$401.85
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital (Anaes.)
50516	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$361.55 <b>Benefit:</b> 75% = \$271.20

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)
50520	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$482.00 <b>Benefit:</b> 75% = \$361.50
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.)
50524	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$415.05 <b>Benefit:</b> 75% = \$311.30
	RADIUS OR ULNA, shaft of, <i>with open growth plate</i> , treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)
50528	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$669.55 <b>Benefit:</b> 75% = \$502.20
	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.)
50532	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$582.55 <b>Benefit:</b> 75% = \$436.95
	RADIUS AND ULNA, shafts of, with open growth plates, treatment of fracture of, by open reduction (Anaes.) (Assist.)
50536	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$776.65 <b>Benefit:</b> 75% = \$582.50
	OLECRANON, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)
50540	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$535.75 <b>Benefit:</b> 75% = \$401.85
	RADIUS, with open growth plate, treatment of fracture of head or neck of, by closed reduction of (Anaes.)
50544	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$267.80 <b>Benefit:</b> 75% = \$200.85 85% = \$227.65
	RADIUS, with open growth plate, treatment of fracture of head or neck of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)
50548	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$535.75 <b>Benefit:</b> 75% = \$401.85
	HUMERUS, proximal, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)
50552	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$462.05 <b>Benefit:</b> 75% = \$346.55
	HUMERUS, proximal, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)
50556	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$615.90 <b>Benefit:</b> 75% = \$461.95
50560	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by closed reduction, undertaken

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDIC
	in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)
	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$482.00 <b>Benefit:</b> 75% = \$361.50
	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)
50564	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$642.75 <b>Benefit:</b> 75% = \$482.10
	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)
50568	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$562.45 <b>Benefit:</b> 75% = \$421.85
	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)
50572	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$749.90 <b>Benefit:</b> 75% = \$562.45
	FEMUR, with open growth plate, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.)
50576	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$615.90 <b>Benefit:</b> 75% = \$461.95 85% = \$531.20
	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.)
50580	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$642.75 <b>Benefit:</b> 75% = \$482.10
	TIBIA, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)
50584	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$615.90 <b>Benefit:</b> 75% = \$461.95
	TIBIA AND FIBULA, with open growth plates, treatment of fracture of, by internal fixation (Anaes.) (Assist.)
50588	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$803.35 <b>Benefit:</b> 75% = \$602.55
	SPINE SURGERY FOR SCOLIOSIS AND KYPHOSIS IN PAEDIATRIC PATIENTS
	SCOLIOSIS OR KYPHOSIS, in a growing child, manipulation of deformity and application of a localiser cast, under general anaesthesia, in a hospital (Anaes.) (Assist.)
50600	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$441.65 <b>Benefit:</b> 75% = \$331.25
	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.)
50604	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$1,874.55 <b>Benefit:</b> 75% = \$1405.95
50608	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	fusion of the spine, not being a service to which item 51011 to 51171 applies	s (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,481.80 <b>Benefit:</b> 75% = \$2611.35	
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity instrumentation, utilising separate anterior and posterior approaches, not being item 51011 to 51171 applies (Anaes.) (Assist.)	
50612	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,952.50 <b>Benefit:</b> 75% = \$3714.40	
	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or remoinstrumentation used for correction of spine deformity (Anaes.) (Assist.)	val of segmental
50616	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$629.25 <b>Benefit:</b> 75% = \$471.95	
	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, in osteotomy, fusion, removal of instrumentation or instrumentation, not being 51011 to 51171 applies (Anaes.) (Assist.)	
50620	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,481.80 <b>Benefit:</b> 75% = \$2611.35	
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and Zielke or similar) - not more than 4 levels (Anaes.) (Assist.)	segmental fixation (Dwyer,
50624	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,481.80 <b>Benefit:</b> 75% = \$2611.35	
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and Zielke or similar) - more than 4 levels (Anaes.) (Assist.)	segmental fixation (Dwyer,
50628	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,300.95 <b>Benefit:</b> 75% = \$3225.75	
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental i of the spine down to and including the pelvis or sacrum, not being a service 51171 applies (Anaes.) (Assist.)	
50632	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$3,615.60 <b>Benefit:</b> 75% = \$2711.70	
	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the resection and instrumentation in the presence of spinal cord involvement, no item 51011 to 51171 applies (Anaes.) (Assist.)	
50636	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$4,017.35 <b>Benefit:</b> 75% = \$3013.05	
	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abranterior or posterior approach, not being a service to which item 51011 to 51 (Assist.)	
50640	(See para TN.8.118 of explanatory notes to this Category) <b>Fee:</b> \$2,220.75 <b>Benefit:</b> 75% = \$1665.60	
	SPINE, bone graft to, for a child or adolescent, associated with surgery for c kyphosis or both (Anaes.) (Assist.)	orrection of scoliosis or
50644	(See para TN.8.118 of explanatory notes to this Category)	

T8. SU	RGICAL OPERATIONS	3	15. ORTHOPAEDIC
	Fee: \$2,142.70 H	<b>Benefit:</b> 75% = \$1607.05	
	TREATMEN	NT OF HIP DYSPLASIA OR DISLOCATI	ON IN PAEDIATRIC PATIENTS
	HIP DYSPLASIA or l under anaesthesia (An		n, manipulation and arthrography of the hip
50650		splanatory notes to this Category) <b>Benefit:</b> 75% = \$316.05  85% = \$358.20	
	HIP DYSPLASIA or I examination of the hip		or reapplication of a hip spica, including
50654		splanatory notes to this Category) <b>Benefit:</b> 75% = \$378.45	
	HIP DYSPLASIA or I anaesthesia (Anaes.)	DISLOCATION, in a child, examination	and manipulation of the hip under
50658		xplanatory notes to this Category) <b>Benefit:</b> 75% = \$150.70	
T8. SU	RGICAL OPERATIONS		DIOFREQUENCY AND MICROWAVE TISSUE ABLATION
	Group T8. Surgical O	perations	
		Subgroup 16. Radiofrequency And Micr	rowave Tissue Ablation
	ablation or percutaneo	malignant tumour of the liver, destruction bus microwave tissue ablation (including the with a service to which item 30419 or	any associated imaging services), other
	(Anaes.)		
50950		<b>Benefit:</b> 75% = \$622.65 85% = \$745.45	
	radiofrequency ablation imaging services), if a	ave tissue ablation cannot be performed of	
	(a) percutaneous acces	ss cannot be achieved;	
		ues are at risk of damage from the percu ave tissue ablation procedure;	taneous radiofrequency ablation or
			is at least one primary liver tumour in an ency ablation or microwave tissue ablation;
	other than a service as	sociated with a service to which item 30	0419 or 50950 applies.
			11
	(Anaes.)		

TO 6116	RGICAL OPERAT	TIONS	16. RADIOFREQUENCY AND MICROWAVE TISSUE ABLATION
16. 301	Fee: \$830.15	<b>Benefit:</b> 75% = \$622.65 8	
T8. SUF	RGICAL OPERAT		17. SPINAL SURGERY
	Group 18. Surg	gical Operations	
			ıp 17. Spinal Surgery
	spinal release, o		total laminectomy, partial vertebrectomy or posterior service associated with a service to which item 51012,)
51011	(See para TN.8.14 <b>Fee:</b> \$1,458.45	41, TN.8.142 of explanatory notes to <b>Benefit:</b> 75% = \$1093.85	o this Category)
	spinal release, 2		total laminectomy, partial vertebrectomy or posterior ervice associated with a service to which item 51011,
51012	(See para TN.8.14 <b>Fee:</b> \$1,944.40	41, TN.8.142 of explanatory notes to <b>Benefit:</b> 75% = \$1458.30	o this Category)
	spinal release, 3		total laminectomy, partial vertebrectomy or posterior ervice associated with a service to which item 51011,)
51013	(See para TN.8.14 <b>Fee:</b> \$2,430.55	41, TN.8.142 of explanatory notes to <b>Benefit:</b> 75% = \$1822.95	o this Category)
	spinal release, 4		total laminectomy, partial vertebrectomy or posterior ervice associated with a service to which item 51011,)
51014	(See para TN.8.14 <b>Fee:</b> \$2,916.65	41, TN.8.142 of explanatory notes to <b>Benefit:</b> 75% = \$2187.50	o this Category)
	spinal release, n		total laminectomy, partial vertebrectomy or posterior of being a service associated with a service to which item (Assist.)
51015	(See para TN.8.14 <b>Fee:</b> \$3,402.75	41, TN.8.142 of explanatory notes to <b>Benefit:</b> 75% = \$2552.10	o this Category)
		cle, or simple interspinous wiring	ion segment) including pars interarticularis, spinous g between 2 adjacent vertebral levels, not being a service
	(a) interspinous	dynamic stabilisation devices; of	OT .
	(b) a service to	which item 51021, 51022, 5102	3, 51024, 51025 or 51026 applies (Anaes.) (Assist.)
51020	(See para TN.8.14 <b>Fee:</b> \$777.70	41, TN.8.143 of explanatory notes to <b>Benefit:</b> 75% = \$583.30	o this Category)
	Fixation of moti sublaminar tape	ion segment with vertebral body	screw, pedicle screw or hook instrumentation including not being a service associated with a service to which 026 applies (Anaes.) (Assist.)
51021	(See para TN.8.14	41, TN.8.143 of explanatory notes to	o this Category)

T8. SUF	GICAL OPERATIONS		17. SPINAL SURGERY
	Fee: \$1,301.70 Benefit	<b>t:</b> 75% = \$976.30	
	sublaminar tapes or wires, 2	with vertebral body screw, pedicle scremotion segments, not being a service as 51024, 51025 or 51026 applies (Anaes.)	ssociated with a service to which
51022		of explanatory notes to this Category) <b>t:</b> 75% = \$1214.40	
	sublaminar tapes or wires, 3	with vertebral body screw, pedicle scre or 4 motion segments, not being a servi 51024, 51025 or 51026 applies (Anaes.)	ice associated with a service to which
51023		of explanatory notes to this Category) <b>t:</b> 75% = \$1445.25	
	sublaminar tapes or wires, 5	with vertebral body screw, pedicle scre or 6 motion segments, not being a servi 51023, 51025 or 51026 applies (Anaes.)	ice associated with a service to which
51024	_	of explanatory notes to this Category) <b>t:</b> 75% = \$1668.50	
	sublaminar tapes or wires, 7	with vertebral body screw, pedicle screto 12 motion segments, not being a serv 1022, 51023, 51024 or 51026 applies (A	vice associated with a service to
51025	_	of explanatory notes to this Category) <b>t:</b> 75% = \$1950.15	
	sublaminar tapes or wires, m	with vertebral body screw, pedicle scremore than 12 motion segments, not being , 51022, 51023, 51024 or 51025 applies	g a service associated with a service
51026		of explanatory notes to this Category) <b>t:</b> 75% = \$2135.10	
		erolateral bone graft to, one motion segr s 51032, 51033, 51034, 51035 or 51036	
51031	(See para TN.8.141, TN.8.144 c <b>Fee:</b> \$956.50 <b>Benefit</b>	of explanatory notes to this Category) <b>t:</b> 75% = \$717.40	
		erolateral bone graft to, 2 motion segme 51031, 51033, 51034, 51035 or 51036	
51032	•	of explanatory notes to this Category) <b>t:</b> 75% = \$860.90	
		erolateral bone graft to, 3 motion segme i 51031, 51032, 51034, 51035 or 51036	
51033	_	of explanatory notes to this Category) <b>t:</b> 75% = \$1004.40	
		erolateral bone graft to, 4 to 7 motion se which item 51031, 51032, 51033, 51035	
51034		of explanatory notes to this Category) <b>t:</b> 75% = \$1076.10	
51035	Spine, posterior and/or poste	erolateral bone graft to, 8 to 11 motion s	segments, not being a service

T8. SUF	GICAL OPERATIONS	17. SPINAL SURGERY
	associated with a service to which item 51031, 51032, 51033, 51034 or	r 51036 applies (Anaes.) (Assist.)
	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) <b>Fee:</b> \$1,530.40 <b>Benefit:</b> 75% = \$1147.80	
	Spine, posterior and/or posterolateral bone graft to, 12 or more motion associated with a service to which item 51031, 51032, 51033, 51034 or	
51036	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) <b>Fee:</b> \$1,626.10 <b>Benefit:</b> 75% = \$1219.60	
	Spinal fusion, anterior column (anterior, direct lateral or posterior interbeing a service associated with a service to which item 51042, 51043, (Assist.)	
51041	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$1,100.00 <b>Benefit:</b> 75% = \$825.00	
	Spinal fusion, anterior column (anterior, direct lateral or posterior interbeing a service associated with a service to which item 51041, 51043, (Assist.)	
51042	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$1,540.05 <b>Benefit:</b> 75% = \$1155.05	
	Spinal fusion, anterior column (anterior, direct lateral or posterior interbeing a service associated with a service to which item 51041, 51042, (Assist.)	
51043	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$1,925.05 <b>Benefit:</b> 75% = \$1443.80	
	Spinal fusion, anterior column (anterior, direct lateral or posterior interbeing a service associated with a service to which item 51041, 51042, (Assist.)	
51044	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$2,090.05 <b>Benefit:</b> 75% = \$1567.55	
	Spinal fusion, anterior column (anterior, direct lateral or posterior intersegments, not being a service associated with a service to which item 5 applies (Anaes.) (Assist.)	
51045	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) <b>Fee:</b> \$2,200.05 <b>Benefit:</b> 75% = \$1650.05	
	Pedicle subtraction osteotomy, one vertebra, not being a service associ item 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 appl	
51051	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$1,879.60 <b>Benefit:</b> 75% = \$1409.70	
	Pedicle subtraction osteotomy, 2 vertebrae, not being a service associatiem 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 appl	
51052	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,286.00 <b>Benefit:</b> 75% = \$1714.50	
51053	Vertebral column resection osteotomy performed through single poster being a service associated with a service to which item 51051, 51052, 51058 or 51059 applies (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,600.95 <b>Benefit:</b> 75% = \$1950.75	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtremoval of more than 50% of the vertebral body), one vertebra, not being a	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51055, 51056, 51057, 510 (Assist.)	058 or 51059 applies (Anaes.)
51054	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$1,386.85 <b>Benefit:</b> 75% = \$1040.15	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtremoval of more than 50% of the vertebral body), 2 vertebrae, not being a subtremoval of more than 50% of the vertebral body).	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51056, 51057, 510 (Assist.)	058 or 51059 applies (Anaes.)
51055	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,080.25 <b>Benefit:</b> 75% = \$1560.20	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or subtremoval of more than 50% of the vertebral body), 3 or more vertebrae, not with:	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, 510 (Assist.)	058 or 51059 applies (Anaes.)
51056	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,426.95 <b>Benefit:</b> 75% = \$1820.25	
	Vertebral body, en bloc excision of (complete spondylectomy), one vertebrassociated with:	a, not being a service
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 510 (Assist.)	058 or 51059 applies (Anaes.)
51057	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,438.40 <b>Benefit:</b> 75% = \$1828.80	
	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebrae associated with:	, not being a service
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 510 (Assist.)	057 or 51059 applies (Anaes.)
51058	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$2,743.70 <b>Benefit:</b> 75% = \$2057.80	
51059	Vertebral body, en bloc excision of (complete spondylectomy), 3 or more v	vertebrae, not being a service

T8. SU	RGICAL OPERATIONS 17. SPINAL SURGERY
	associated with:
	(a) anterior column fusion when at the same motion segment; or
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, 51057 or 51058 applies (Anaes.) (Assist.)
	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) <b>Fee:</b> \$3,352.80 <b>Benefit:</b> 75% = \$2514.60
	Spinal fusion, anterior and posterior, including spinal instrumentation at one motion segment, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51062, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)
51061	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$2,880.00 <b>Benefit:</b> 75% = \$2160.00
	Spinal fusion, anterior and posterior, including spinal instrumentation at 2 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51063, 51064, 51065 or 51066 applies (Anaes.) (Assist.)
51062	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$3,733.15 <b>Benefit:</b> 75% = \$2799.90
	Spinal fusion, anterior and posterior, including spinal instrumentation at 3 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51064, 51065 or 51066 applies (Anaes.) (Assist.)
51063	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$4,521.55 <b>Benefit:</b> 75% = \$3391.20
	Spinal fusion, anterior and posterior, including spinal instrumentation at 4 to 7 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51065 or 51066 applies (Anaes.) (Assist.)
51064	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$5,032.10 <b>Benefit:</b> 75% = \$3774.10
	Spinal fusion, anterior and posterior, including spinal instrumentation at 8 to 11 motion segments, posterior and/or posterolateral bone graft, and anterior column fusion, not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51066 applies (Anaes.) (Assist.)
51065	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$5,565.45 <b>Benefit:</b> 75% = \$4174.10
	Spinal fusion, anterior and posterior, including spinal instrumentation at 12 or more motion segments, posterior and/or posterolateral bone graft, and anterior column fusion not being a service associated with a service to which item 51061, 51062, 51063, 51064 or 51065 applies (Anaes.) (Assist.)
51066	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) <b>Fee:</b> \$5,859.80 <b>Benefit:</b> 75% = \$4394.85
	Removal of intradural lesion, not being a service associated with a service to which item 51072 or 51073 applies (Anaes.) (Assist.)
51071	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$2,540.00 <b>Benefit:</b> 75% = \$1905.00
51072	Craniocervical junction lesion, transoral approach for, not being a service associated with a service to which item 51071 or 51073 applies (Anaes.) (Assist.)

T8. SURGICAL OPERATIONS 17. SPINAL SURG	
	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$2,641.60 <b>Benefit:</b> 75% = \$1981.20
	Removal of intramedullary tumour or arteriovenous malformation, not being a service associated with service to which item 51071 or 51072 applies (Anaes.) (Assist.)
51073	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$3,352.80 <b>Benefit:</b> 75% = \$2514.60
	Thoracoplasty in combination with thoracic scoliosis correction—3 or more ribs (Anaes.) (Assist.)
51102	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$1,202.35 <b>Benefit:</b> 75% = \$901.80
	Odontoid screw fixation (Anaes.) (Assist.)
51103	(See para TN.8.141, TN.8.148 of explanatory notes to this Category) <b>Fee:</b> \$2,113.05 <b>Benefit:</b> 75% = \$1584.80
	Spine, treatment of fracture, dislocation or fracture dislocation, with immobilisation by calipers or halo not including application of skull tongs or calipers as part of operative positioning (Anaes.)
51110	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$765.30 <b>Benefit:</b> 75% = \$574.00 85% = \$680.60
	Skull calipers or halo, insertion of, as an independent procedure (Anaes.)
51111	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$325.25 <b>Benefit:</b> 75% = \$243.95
	Plaster jacket, application of, as an independent procedure (Anaes.)
51112	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$219.95 <b>Benefit:</b> 75% = \$165.00  85% = \$187.00
	Halo, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.)
51113	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$243.90 <b>Benefit:</b> 75% = \$182.95
	Halo thoracic orthosis—application of both halo and thoracic jacket (Anaes.)
51114	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$430.55 <b>Benefit:</b> 75% = \$322.95
	Halo femoral traction, as an independent procedure (Anaes.)
51115	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$430.55 <b>Benefit:</b> 75% = \$322.95  85% = \$366.00
	Bone graft, harvesting of autogenous graft, via separate incision or via subcutaneous approach, in conjunction with spinal fusion, other than for the purposes of bone graft obtained from the cervical, thoracic, lumbar or sacral spine (Anaes.)
51120	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$239.25 <b>Benefit:</b> 75% = \$179.45
	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal disc and marginal osteophytes:
51130	(a) for a patient who:

T8. SUF	RGICAL OPERATIONS 17. SPINAL SURG	ERY
	(i) has not had prior spinal fusion surgery at the same lumbar level; and	
	(ii) does not have vertebral osteoporosis; and	
	(iii) has failed conservative therapy; and	
	(b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 5101 applies (Anaes.) (Assist.)	15
	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$1,822.35 <b>Benefit:</b> 75% = \$1366.80	
	Cervical artificial intervertebral total disc replacement, at one motion segment only, including remo of disc and marginal osteophytes, for a patient who:	val
	(a) has not had prior spinal surgery at the same cervical level; and	
	(b) is skeletally mature; and	
	(c) has symptomatic degenerative disc disease with radiculopathy; and	
	(d) does not have vertebral osteoporosis; and	
	(e) has failed conservative therapy (Anaes.) (Assist.)	
51131	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$1,100.00 <b>Benefit:</b> 75% = \$825.00	
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation up to motion segments, not being a service associated with a service to which item 51141 applies (Anaes. (Assist.)	
51140	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$449.55 <b>Benefit:</b> 75% = \$337.20	
	Previous spinal fusion, re-exploration for, involving adjustment or removal of instrumentation more 3 motion segments, not being a service associated with a service to which item 51140 applies (Anae (Assist.)	
51141	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$831.65 <b>Benefit:</b> 75% = \$623.75	
	Wound debridement or excision for post operative infection or haematoma following spinal surgery (Anaes.) (Assist.)	7
51145	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$449.55 <b>Benefit:</b> 75% = \$337.20	
	Coccyx, excision of (Anaes.) (Assist.)	
51150	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$452.55 <b>Benefit:</b> 75% = \$339.45	
	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which ite 51165 applies (Anaes.) (Assist.)	m
51160	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) <b>Fee:</b> \$1,168.40 <b>Benefit:</b> 75% = \$876.30	
51165	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being a service to	.0

T8. SUF	RGICAL OPERATIONS 17. SPINAL SURGERY
	which item 51160 applies (Anaes.) (Assist.)
	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) <b>Fee:</b> \$1,473.20 <b>Benefit:</b> 75% = \$1104.90
	Syringomyelia or hydromyelia, craniotomy for, with or without duraplasty, intradural dissection, plugging of obex or local cerebrospinal fluid shunt (Anaes.) (Assist.)
51170	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$2,219.55 <b>Benefit:</b> 75% = \$1664.70
	Syringomyelia or hydromyelia, treatment by direct cerebrospinal fluid shunt (for example, syringosubarachnoid shunt, syringopleural shunt or syringoperitoneal shunt) (Anaes.) (Assist.)
51171	(See para TN.8.141 of explanatory notes to this Category) <b>Fee:</b> \$932.10 <b>Benefit:</b> 75% = \$699.10
T9. ASS	SISTANCE AT OPERATIONS
	Group T9. Assistance At Operations
	Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$567.25 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 \$567.25
51300	(See para TN.9.2, TN.9.1 of explanatory notes to this Category) <b>Fee:</b> \$87.70 <b>Benefit:</b> 75% = \$65.80 85% = \$74.55
	Assistance at any operation identified by the word "Assist." for which the fee exceeds \$567.25 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$567.25.
51303	(See para TN.9.1, TN.9.3 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the operation or combination of operations
	Assistance at a birth involving Caesarean section
51306	(See para TN.9.1 of explanatory notes to this Category) <b>Fee:</b> \$126.65 <b>Benefit:</b> 75% = \$95.00 85% = \$107.70
	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a birth involving Caesarean section
51309	(See para TN.9.1, TN.9.4 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627
51312	(See para TN.4.11, TN.9.1 of explanatory notes to this Category) <b>Derived Fee:</b> one fifth of the established fee for the procedure or combination of procedures
	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779
51315	(See para TN.9.1 of explanatory notes to this Category) <b>Fee:</b> \$276.75 <b>Benefit:</b> 75% = \$207.60 85% = \$235.25
51318	Assistance at cataract and intraocular lens surgery where patient has:

#### T9. ASSISTANCE AT OPERATIONS

- 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 TN.9.5, TN.9.1 of explanatory notes to this Category) **Fee:** \$182.65 **Benefit:** 75% = \$137.00 85% = \$155.30

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

1. HEAD

	LE SERVICE 1. HEAD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 1. Head
	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)
20100	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units)
20102	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units)
20104	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units)
20120	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units)
20124	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units)
20140	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units)
20142	Fee: \$100.50 Benefit: 75% = \$75.40 85% = \$85.45 Extended Medicare Safety Net Cap: \$80.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units)
20143	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units)

1. HEAD

<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units)
<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units)
<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
INITIATION OF MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units)
Fee: \$120.60 Benefit: 75% = \$90.45 85% = \$102.55
INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units)
Fee: \$80.40 Benefit: 75% = \$60.30 85% = \$68.35
Initiation of the management of anaesthesia for intranasal or accessory sinuses, not being a service to which another item in this Subgroup applies (6 basic units)
<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal
ablation (7 basic units)
<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units)
<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, no being a service to which another item in this Subgroup applies (6 basic units)
<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units)
<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units)
<b>Fee:</b> \$180.90 <b>Benefit:</b> 75% = \$135.70 85% = \$153.80
INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)
<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85
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)
<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units)

ANAES	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN
	LE SERVICE 1. HEAD
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units)
20210	<b>Fee:</b> \$301.50 <b>Benefit:</b> 75% = \$226.15 85% = \$256.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units)
20212	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units)
20214	<b>Fee:</b> \$180.90 <b>Benefit:</b> 75% = \$135.70 85% = \$153.80
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units)
20216	<b>Fee:</b> \$402.00 <b>Benefit:</b> 75% = \$301.50 85% = \$341.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units)
20220	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units)
20222	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units)
20225	<b>Fee:</b> \$241.20 <b>Benefit:</b> 75% = \$180.90 85% = \$205.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the head or face (12 basic units)
20230	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$241.20 <b>Benefit:</b> 75% = \$180.90 85% = \$205.05
ANAES ONLY F PERFO	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 2. NECK
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 2. Neck
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units)
20300	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45

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

ANAES	ELATIVE VALUE O THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC	ARE BENEFITS ARE NAESTHESIA	
	LE SERVICE	2. NECK	
	basic units)		
	<b>Fee:</b> \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30	
	trachea, lymphati	F MANAGEMENT OF ANAESTHESIA for procedures on oesophagus, thyroid, larynx, ic system, muscles, nerves or other deep tissues of the neck, not being a service to em in this Subgroup applies (6 basic units)	
20320	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
		F MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, ctomy or pharyngectomy (10 basic units)	
20321	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF and mouth) (8 ba	F MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose units)	
20330	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70	
		MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not which another item in this Subgroup applies (10 basic units)	
20350	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF basic units)	F MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5	
20352	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery kk (12 basic units)	
		3 of explanatory notes to this Category)	
20355	<b>Fee:</b> \$241.20	<b>Benefit:</b> 75% = \$180.90 85% = \$205.05	
ANAES ONLY F PERFO	ELATIVE VALUE ( THESIA - MEDICA PAYABLE FOR AN RMED IN ASSOC LE SERVICE	ARE BENEFITS ARE NAESTHESIA	
ELIGIB	LE SERVICE	3. I HORAX	
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
		Subgroup 3. Thorax	
		MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous rior part of the chest, not being a service to which another item in this Subgroup applies	
20400	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30	
20401		MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a another item in this Subgroup applies (4 basic units)	
20401			

3. THORAX

	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5	
20402	<b>Fee:</b> \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
		MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast nere axillary node dissection is performed (5 basic units)	
20403	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units)	
20404	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
		MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast us flaps (8 basic units)	
20405	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70	
		MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on l mammary node dissection (13 basic units)	
20406	<b>Fee:</b> \$261.30	<b>Benefit:</b> 75% = \$196.00 85% = \$222.15	
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4	
20410	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	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)		
20420	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	INITIATION OF sternum (4 basic u	MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the nits)	
20440	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
		MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum to which another item in this Subgroup applies (5 basic units)	
20450	<b>Fee:</b> \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	INITIATION OF sternum (6 basic u	MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or nits)	
20452	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
		MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to a in this Subgroup applies (6 basic units)	
20470	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
20472	INITIATION OF	MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)	

3. THORAX

	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OI units)	MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic
20474	(See para TN.10.2 <b>Fee:</b> \$261.30	c of explanatory notes to this Category) <b>Benefit:</b> 75% = \$196.00 85% = \$222.15
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery erior or posterior thorax (10 basic units)
	(See para TN.10.2	of explanatory notes to this Category)
20475	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

4. INTRATHORACIC

	Group T10, Rela	ntive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
		formed In Association With An Eligible Service
		Subgroup 4. Intrathoracic
	INITIATION OF basic units)	F MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15
20500	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30
		F MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid or bronchoscopy), not being a service to which another item in this Subgroup applies (6
20520	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units)
20522	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units)
20524	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units)
20526	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units)
20528	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
		MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, m, or mediastinum, not being a service to which another item in this Subgroup applies
20540	Fee: \$261.30	<b>Benefit:</b> 75% = \$196.00 85% = \$222.15

#### 4. INTRATHORACIC

	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units)
20542	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30
		F MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty
	(15 basic units)	
20546	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30
	INITIATION OF and bronchi (15)	F MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea basic units)
20548	<b>Fee:</b> \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30
	Initiation of the r	management of anaesthesia for:
	(a) open procedu	ares on the heart, pericardium or great vessels of the chest; or
	(b) percutaneous	insertion of a valvular prosthesis (20 basic units)
20560	Fee: \$402.00	<b>Benefit:</b> 75% = \$301.50 85% = \$341.70

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

#### 5. SPINE AND SPINAL CORD

	•	ntive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
		Subgroup 5. Spine And Spinal Cord
	not being a servi	F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, ce to which another item in this Subgroup applies (for myelography and discography and 21914) (10 basic units)
20600	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
		F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ing position (13 basic units)
20604	Fee: \$261.30	<b>Benefit:</b> 75% = \$196.00 85% = \$222.15
		F MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, ce to which another item in this Subgroup applies (10 basic units)
20620	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic
20622	Fee: \$261.30	<b>Benefit:</b> 75% = \$196.00 85% = \$222.15
20630	INITIATION OF	MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a

#### 5. SPINE AND SPINAL CORD

	service to which	another item in this Subgroup applies (8 basic units)
	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units)
20632	<b>Fee:</b> \$140.70	<b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units)
20634	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION Of procedures (13 b	F MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord pasic units)
	(See para TN.10.2	3 of explanatory notes to this Category)
20670	Fee: \$261.30	<b>Benefit:</b> 75% = \$196.00 85% = \$222.15
		F MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in eatre of a hospital (3 basic units)
20680	<b>Fee:</b> \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
		F MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being the another item in this Subgroup applies (5 basic units)
20690	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45

# T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

#### 6. UPPER ABDOMEN

ELIGIB	LE SERVICE	6. UPPER ABDOMEN
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 6. Upper Abdomen
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous per anterior abdominal wall, not being a service to which another item in this Subgroup units)
20700	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)
20702	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	tendons and fase	F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, cia of the upper abdominal wall, not being a service to which another item in this es (4 basic units)
20703	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
20704	INITIATION O	F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery

#### 6. UPPER ABDOMEN

LLIGIB	LE SERVICE 0. OFFER ADDOME
	involving the anterior or posterior upper abdomen (10 basic units)
	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	Initiation of the management of anaesthesia for laparoscopic procedures in the upper abdomen, including laparoscopic cholecystectomy, not being a service to which another item in this Subgroup applies (7 basic units)
20706	(See para TN.10.27 of explanatory notes to this Category) <b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units)
20730	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units)
20740	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	Initiation of the management of anaesthesia for either or both of the following:  (a) upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (b) endoscopic retrograde cholangiopancreatography (7 basic units)
20745	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	Initiation of the management of anaesthesia for hernia repairs to the upper abdominal wall, other than a service to which another item in this Subgroup applies. (5 basic units)
20750	(See para TN.10.27 of explanatory notes to this Category) <b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units)
20752	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units)
20754	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units)
20756	<b>Fee:</b> \$180.90 <b>Benefit:</b> 75% = \$135.70 85% = \$153.80
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units)
20770	<b>Fee:</b> \$301.50 <b>Benefit:</b> 75% = \$226.15 85% = \$256.30
20790	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen, including any of the following:  (a) open cholecystectomy;

ANAES ONLY P PERFOI	LATIVE VALUE GUIDE FOR IHESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 6. UPPER ABDOMEN
	(b) gastrectomy; (c) laparoscopically assisted nephrectomy; (d) bowel shunts (8 basic units)
	<b>Fee:</b> \$160.80 <b>Benefit:</b> 75% = \$120.60 85% = \$136.70
	Initiation of the management of anaesthesia for bariatric surgery in a patient with clinically severe obesity (10 basic units)
20791	(See para TN.8.29 of explanatory notes to this Category) <b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units)
20792	<b>Fee:</b> \$261.30 <b>Benefit:</b> 75% = \$196.00 85% = \$222.15
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units)
20793	<b>Fee:</b> \$301.50 <b>Benefit:</b> 75% = \$226.15 85% = \$256.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units)
20794	<b>Fee:</b> \$241.20 <b>Benefit:</b> 75% = \$180.90 85% = \$205.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units)
20798	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra- abdominal organ in the upper abdomen (6 basic units)
20799	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
ANAES ONLY P PERFOI	LATIVE VALUE GUIDE FOR ITHESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 7. LOWER ABDOMEN
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 7. Lower Abdomen
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units)
20800	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	Deficite 1570 - \$45.25 0570 - \$51.50

# 7. LOWER ABDOMEN

	units)	
	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, as of the lower abdominal wall, not being a service to which another item in this (4 basic units)
20803	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery erior or posterior lower abdomen (10 basic units)
20804	(See para TN.10.28 <b>Fee:</b> \$201.00	B of explanatory notes to this Category)  Benefit: 75% = \$150.75 85% = \$170.85
	INITIATION OF abdomen (7 basic	F MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower cunits)
20806	Fee: \$140.70	<b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4
20810	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF urinary tract (6 b	MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to asic units)
20815	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or sue of the lower posterior abdominal wall (5 basic units)
20820	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being h another item in this Subgroup applies (4 basic units)
20830	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound lower abdomen (6 basic units)
20832	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
		nanagement of anaesthesia for all open procedures within the lower abdominal including appendicectomy, not being a service to which another item in this Subgroup units)
20840	(See para TN.10.27) <b>Fee:</b> \$120.60	7 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$90.45  85% = \$102.55
		F MANAGEMENT OF ANAESTHESIA for bowel resection, including laparoscopic not being a service to which another item in this Subgroup applies (8 basic units)
20841	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70

# 7. LOWER ABDOMEN

	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units)	
20842	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units)	
20844	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units)	
20845	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units)	
20846	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units)	
20847	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units)	
20848	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units)	
20850	<b>Fee:</b> \$241.20 <b>Benefit:</b> 75% = \$180.90 85% = \$205.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy within 24 hours of birth (15 basic units)	
20855	<b>Fee:</b> \$301.50 <b>Benefit:</b> 75% = \$226.15 85% = \$256.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units)	
20860	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units)	
20862	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units)	
20863	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units)	
20864	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units)	
20866	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	
20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units)	

#### 7. LOWER ABDOMEN

	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient)
	(10 basic units)	
20868	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
		MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal
	vessels, not being	g a service to which another item in this subgroup applies (15 basic units)
20880	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units)
20882	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
		F MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic
	units)	
20884	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-
	abdominal organ	in the lower abdomen (6 basic units)
20886	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

#### 8. PERINEUM

LLIGIB	IDEL OLIVVICE	O. I LINII4LOW
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Onl Anaesthesia Performed In Association With An Eligible Service	y Payable For
	Subgroup 8. Perineum	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the ski tissue of the perineum not being a service to which another item in this Subgroup a	
20900	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30	
	Initiation of the management of anaesthesia for anorectal procedures (including sur haemorrhoidectomy, but not banding of haemorrhoids) (4 basic units)	gical
20902	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal proceduradical perineal prostatectomy or radical vulvectomy (7 basic units)	edures including
20904	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tis involving the perineum (10 basic units)	ssue flap surgery
	(See para TN.10.28 of explanatory notes to this Category)	
20905	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85	

8. PERINEUM

	INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units)	
20906	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units)	
20910	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery including laser procedures (5 basic units)	
20911	(See para TN.10.29 of explanatory notes to this Category) <b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units)	
20912	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 bas units)	ic
20914	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units)	
20916	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60	
	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units)	
20920	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units)	
20924	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach basic units)	(4
20926	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approa (6 basic units)	ich
20928	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 bass units)	ic
20930	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
20932	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units)	

8. PERINEUM

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8. PERINEUM

		F MANAGEMENT OF ANAESTHESIA for evacuation of retained products of complication of confinement (4 basic units)
20956	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for or perineal tear following birth (5 basic units)
20958	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of morrhage (blood loss > 500mls) (7 basic units)
20960	Fee: \$140.70	<b>Benefit:</b> 75% = \$105.55 85% = \$119.60

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

9. PELVIS (EXCEPT HIP)

LLIGID	LL SLIVICE	5. FEEVIS (EXCEPT TIIF)
		ive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For ormed In Association With An Eligible Service
		Subgroup 9. Pelvis (Except Hip)
		MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous or pelvic region (anterior to iliac crest), except external genitalia (3 basic units)
21100	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
		MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or ne of the pelvic region (posterior to iliac crest), except perineum (5 basic units)
21110	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF anterior iliac crest	MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the (4 basic units)
21112	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF posterior iliac cres	MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the st (5 basic units)
21114	<b>Fee:</b> \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF from the pelvis (6	MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting basic units)
21116	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic
21120	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
21130	INITIATION OF	MANAGEMENT OF ANAESTHESIA for body cast application or revision when

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN **ELIGIBLE SERVICE** 9. PELVIS (EXCEPT HIP) performed in the operating theatre of a hospital (3 basic units) **Benefit:** 75% = \$45.25 85% = \$51.30 **Fee:** \$60.30 INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units) **Benefit:** 75% = \$226.15 85% = \$256.30 21140 Fee: \$301.50 INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) 21150 Fee: \$201.00 **Benefit:** 75% = \$150.75 85% = \$170.85 INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units) (See para TN.10.28 of explanatory notes to this Category) 21155 Fee: \$201.00 **Benefit:** 75% = \$150.75 85% = \$170.85 INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units) 21160 Fee: \$80.40 **Benefit:** 75% = \$60.30 85% = \$68.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) 21170 Fee: \$160.80 **Benefit:** 75% = \$120.60 85% = \$136.70 T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN **ELIGIBLE SERVICE** 10. UPPER LEG (EXCEPT KNEE) Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service Subgroup 10. Upper Leg (Except Knee) INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) 21195 Fee: \$60.30 **Benefit:** 75% = \$45.25 85% = \$51.30 INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) 21199 Fee: \$80.40 **Benefit:** 75% = \$60.30 85% = \$68.35 INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital (4 basic units)

INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4

**Benefit:** 75% = \$60.30 85% = \$68.35

21200

21202

Fee: \$80.40

# 10. UPPER LEG (EXCEPT KNEE)

LLIGIB	LE SERVICE	10. OFFER LEG (EXCEPT KNEE)
	basic units)	
	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not owhich another item in this Subgroup applies (6 basic units)
21210	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units)
21212	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic
21214	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for bilateral total hip replacement (14 basic
21216	Fee: \$281.40	<b>Benefit:</b> 75% = \$211.05 85% = \$239.20
		F MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of ormed in the operating theatre of a hospital (4 basic units)
21220	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 of a service to which another item in this Subgroup applies (6 basic units)
21230	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units)
21232	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF (8 basic units)	F MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur
21234	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
		F MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, ation (4 basic units)
21260	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, graft, not being a service to which another item in this Subgroup applies (8 basic units)
21270	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units)
21272	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units)
21274	(See para TN.10.24	4 of explanatory notes to this Category)

#### 10. UPPER LEG (EXCEPT KNEE)

	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery per leg (10 basic units)
21275	(See para TN.10.28 <b>Fee:</b> \$201.00	8 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$150.75  85% = \$170.85
	INITIATION OF (15 basic units)	MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg
21280	<b>Fee:</b> \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

#### 11. KNEE AND POPLITEAL AREA

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 11. Knee And Popliteal Area
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units)
21300	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units)
21321	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	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)
21340	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units)
21360	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when performed in the operating theatre of a hospital (3 basic units)
21380	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units)
21382	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
21390	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital (3 basic units)

#### 11. KNEE AND POPLITEAL AREA

	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
		F MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia,
	fibula, and/or pa	tella (4 basic units)
21392	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a
	service to which	another item in this Subgroup applies (4 basic units)
21400	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units)
21402	Fee: \$140.70	<b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units)
21403	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units)
21404	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair
	involving knee j	oint, undertaken in a hospital (3 basic units)
21420	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal service to which another item in this Subgroup applies (4 basic units)
21430	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or
	popliteal area (5	basic units)
21432	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		F 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)
21440	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery ee and/or popliteal area (10 basic units)
	(See para TN.10.2	8 of explanatory notes to this Category)
21445	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

12. LOWER LEG (BELOW KNEE)

Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service

# 12. LOWER LEG (BELOW KNEE)

LE SERVICE 12. LOVVER LEG (BELOW RIVEL)		
	Subgroup 12. Lower Leg (Below Knee)	
	MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous g, ankle, or foot (3 basic units)	
Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30	
	MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or g, ankle, or foot, not being a service to which another item in this Subgroup applies (4	
<b>Fee:</b> \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
INITIATION OF foot (3 basic units	MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or s)	
<b>Fee:</b> \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30	
INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4	
Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
INITIATION OF	MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units)	
<b>Fee:</b> \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
INITIATION OF	MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units)	
<b>Fee:</b> \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, cluding amputation, not being a service to which another item in this Subgroup applies	
Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
INITIATION OF leg, ankle or foot	MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower (5 basic units)	
Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
INITIATION OF (5 basic units)	MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula	
Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
INITIATION OF	MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units)	
Fee: \$140.70	<b>Benefit:</b> 75% = \$105.55 85% = \$119.60	
	MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or in a hospital (3 basic units)	
Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30	
INITIATION OF	MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg,	
	tissue of lower le  Fee: \$60.30  INITIATION OF fascia of lower le basic units)  Fee: \$80.40  INITIATION OF foot (3 basic units)  Fee: \$60.30  INITIATION OF basic units)  Fee: \$80.40  INITIATION OF Fee: \$100.50  INITIATION OF ankle, or foot, inc (4 basic units)  Fee: \$80.40  INITIATION OF ankle, or foot, inc (4 basic units)  Fee: \$100.50  INITIATION OF leg, ankle or foot Fee: \$100.50  INITIATION OF (5 basic units)  Fee: \$100.50  INITIATION OF (5 basic units)  Fee: \$100.50  INITIATION OF (5 basic units)  Fee: \$100.50  INITIATION OF (5 basic units)  Fee: \$100.50  INITIATION OF	

# T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE including bypass graft, not being a service

#### 12. LOWER LEG (BELOW KNEE)

	including bypass	graft, not being a service to which another item in this Subgroup applies (8 basic units)	
	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70	
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic	
21502	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not o which another item in this Subgroup applies (4 basic units)	
21520	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35	
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5	
21522	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	INITIATION Of ankle or foot (15	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, basic units)	
21530	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30	
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8	
21532	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70	
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery wer leg (10 basic units)	
	(See para TN.10.28 of explanatory notes to this Category)		
21535	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85	

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

#### 13. SHOULDER AND AXILLA

LLIOID	LE GENVICE
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 13. Shoulder And Axilla
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)
21600	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)
21610	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
21620	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and

#### 13. SHOULDER AND AXILLA

ELIGIBI	LE SERVICE	13. SHOULDER AND AXILLA
		cular joint, acromioclavicular joint, or shoulder joint when performed in the operating tal (4 basic units)
	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF (5 basic units)	MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint
21622	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	neck, sternoclavio	MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and cular joint, acromioclavicular joint or shoulder joint, not being a service to which his Subgroup applies (5 basic units)
21630	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head lavicular joint, acromioclavicular joint or shoulder joint (6 basic units)
21632	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units)
21634	Fee: \$180.90	<b>Benefit:</b> 75% = \$135.70 85% = \$153.80
	INITIATION OF amputation (15 b	MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) asic units)
21636	<b>Fee:</b> \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units)
21638	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
		MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or a service to which another item in this Subgroup applies (8 basic units)
21650	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
	INITIATION OF (10 basic units)	MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm
21652	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF axilla (8 basic un	MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or its)
21654	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic
21656	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	INITIATION OF (4 basic units)	MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla
21670	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35

#### 13. SHOULDER AND AXILLA

		F MANAGEMENT OF ANAESTHESIA for shoulder cast application, removal or g a service to which another item in this Subgroup applies, when undertaken in a hospital
21680	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
		F MANAGEMENT OF ANAESTHESIA for shoulder spica application when hospital (4 basic units)
21682	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery oulder or the axilla (10 basic units)
	(See para TN.10.2	28 of explanatory notes to this Category)
21685	Fee: \$201.00	<b>Benefit:</b> 75% = \$150.75 85% = \$170.85

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

#### 14. UPPER ARM AND ELBOW

		1.1.51.1.21.71.11.1.71.1.5
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 14. Upper Arm And Elbow
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous er arm or elbow (3 basic units)
21700	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
		F MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, of upper arm or elbow, not being a service to which another item in this Subgroup units)
21710	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION Of (5 basic units)	F MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow
21712	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5
21714	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION Of biceps (5 basic u	F MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of units)
21716	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
21730	INITIATION O	F MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm

#### 14. UPPER ARM AND ELBOW

	or elbow when	performed in the operating theatre of a hospital (3 basic units)
	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	INITIATION O basic units)	F MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4
21732	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or g a service to which another item in this Subgroup applies (5 basic units)
21740	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION O elbow (6 basic u	F MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or units)
21756	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units)
21760	Fee: \$140.70	<b>Benefit:</b> 75% = \$105.55 85% = \$119.60
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not to which another item in this Subgroup applies (8 basic units)
21770	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60 85% = \$136.70
	INITIATION O (6 basic units)	F MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm
21772	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not to which another item in this Subgroup applies (4 basic units)
21780	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery oper arm or elbow (10 basic units)
21785	(See para TN.10.2 <b>Fee:</b> \$201.00	28 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$150.75  85% = \$170.85
	INITIATION O (15 basic units)	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm
21790	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

15. FOREARM WRIST AND HAND

Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service

# 15. FOREARM WRIST AND HAND

	Subgroup 15. Forearm Wrist And Hand		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units)		
21800	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units)		
21810	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35		
	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)		
21820	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30		
	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)		
21830	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units)		
21832	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units)		
21834	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35		
	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)		
21840	<b>Fee:</b> \$160.80 <b>Benefit:</b> 75% = \$120.60 85% = \$136.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units)		
21842	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units)		
21850	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, removal, or repair when rendered to a patient as part of an episode of hospital treatment (3 basic units)		
21860	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the forearm, wrist or hand (10 basic units)		
21865	(See para TN.10.28 of explanatory notes to this Category) <b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75  85% = \$170.85		
21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm,		

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#### 15. FOREARM WRIST AND HAND

	wrist or hand (15 ba	asic units)	
	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15	85% = \$256.30
	INITIATION OF Masic units)	IANAGEMENT OF ANA	ESTHESIA for microsurgical reimplantation of a finger (8
21872	Fee: \$160.80	<b>Benefit:</b> 75% = \$120.60	85% = \$136.70

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

#### 16. ANAESTHESIA FOR BURNS

ELIGIB	LE SERVICE	10. ANAEST RESIA FOR BURNS		
		ve Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For ormed In Association With An Eligible Service		
		Subgroup 16. Anaesthesia For Burns		
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ng where the area of burn involves not more than 3% of total body surface (3 basic		
21878	<b>Fee:</b> \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30		
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ng, where the area of burn involves more than 3% but less than 10% of total body its)		
21879	<b>Fee:</b> \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45		
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ng, where the area of burn involves 10% or more but less than 20% of total body its)		
21880	<b>Fee:</b> \$140.70	<b>Benefit:</b> 75% = \$105.55 85% = \$119.60		
	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)			
21881	Fee: \$180.90	<b>Benefit:</b> 75% = \$135.70 85% = \$153.80		
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ng, where the area of burn involves 30% or more but less than 40% of total body nits)		
21882	Fee: \$221.10	<b>Benefit:</b> 75% = \$165.85 85% = \$187.95		
		MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or ng, where the area of burn involves 40% or more but less than 50% of total body nits)		
21883	Fee: \$261.30	<b>Benefit:</b> 75% = \$196.00 85% = \$222.15		

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
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PERFORMED IN ASSOCIATION WITH AN
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#### 16. ANAESTHESIA FOR BURNS

	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units)		
21884	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15 85% = \$256.30	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units)		
21885	Fee: \$341.70	<b>Benefit:</b> 75% = \$256.30 85% = \$290.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units)		
21886	Fee: \$381.90	<b>Benefit:</b> 75% = \$286.45 85% = \$324.65	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units)		
21887	Fee: \$422.10	<b>Benefit:</b> 75% = \$316.60 85% = \$358.80	

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

LLIOID	LL SLIVIOL	TROOLDORES	
		ntive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service	
	Subgrou	p 17. Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures	
		F MANAGEMENT OF ANAESTHESIA for injection procedure for traphy (3 basic units)	
21900	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30	
	INITIATION OF lumbar or thorac	F MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: ic (5 basic units)	
21906	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45	
	INITIATION OF cervical (6 basic	F MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: units)	
21908	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units)		
21910	Fee: \$180.90	<b>Benefit:</b> 75% = \$135.70 85% = \$153.80	
21912	INITIATION OF	MANAGEMENT OF ANAESTHESIA for injection procedure for discography:	

LLIGID	LL SLIVICE	FROCEDORES
	lumbar or thoraci	c (5 basic units)
	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF cervical (6 basic	MANAGEMENT OF ANAESTHESIA for injection procedure for discography: units)
21914	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units)
21915	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF (5 basic units)	MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral
21916	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF (5 basic units)	F MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral
21918	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, nice scanning, digital subtraction angiography scanning (6 basic units)
21922	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
		MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde retrograde cystourethrography (4 basic units)
21925	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units)
21926	<b>Fee:</b> \$80.40	<b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units)
21930	Fee: \$120.60	<b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units)
21935	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40 85% = \$85.45
		F MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time examination (5 basic units)
21936	(See para TN.10.26 <b>Fee:</b> \$100.50	6 of explanatory notes to this Category) <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic
21939	Fee: \$60.30	<b>Benefit:</b> 75% = \$45.25 85% = \$51.30
21941		F MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary ntriculography, cardiac mapping, insertion of automatic defibrillator or transvenous

LLIGIDI	LE SERVICE PROCEDURES
	pacemaker (7 basic units)
	(See para TN.10.25 of explanatory notes to this Category)
	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units)
21942	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	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)
21943	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units)
21945	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units)
21949	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	Initiation of the management of anaesthesia for diagnostic muscle biopsy to assess for malignant hyperpyrexia (4 basic units)
21952	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)
21955	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units)
21959	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units)
21962	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure if there is a clinical need for anaesthesia, not for headache of any etiology (5 basic units)
21965	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	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)
21969	<b>Fee:</b> \$160.80 <b>Benefit:</b> 75% = \$120.60 85% = \$136.70
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)

ELIGIB	LE SERVICE		PROCEDUR
	Fee: \$301.50	<b>Benefit:</b> 75% = \$226.15	5 85% = \$256.30
	INITIATION Of sources (5 basic		NAESTHESIA for brachytherapy using radioactive sealed
21973	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40	85% = \$85.45
	INITIATION Of units)	F MANAGEMENT OF AN	NAESTHESIA for therapeutic nuclear medicine (5 basic
21976	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40	85% = \$85.45
	INITIATION O	F MANAGEMENT OF AN	NAESTHESIA for radiotherapy (5 basic units)
21980	Fee: \$100.50	<b>Benefit:</b> 75% = \$75.40	) 85% = \$85.45
PERFO	LE SERVICE	CIATION WITH AN	18. MISCELLANEC
	Anaesthesia Pe	rformed In Association W	<del>-</del>
			bgroup 18. Miscellaneous
	INITIATION O	F MANAGEMENT OF AN	NAESTHESIA when no procedure ensues (3 basic units)
21990	(See para TN.10.1 <b>Fee:</b> \$60.30	2 of explanatory notes to this <b>Benefit:</b> 75% = \$45.25	<del>-</del>
		ion with a procedure covere	NAESTHESIA performed on a person under the age of 10 red by an item which has not been identified as attracting a
21992	Fee: \$80.40	<b>Benefit:</b> 75% = \$60.30	) 85% = \$68.35
	item that does no		NAESTHESIA in connection with a procedure covered by es.)", other than a service to which item 21965 or 21992 thesia (4 basic units)
21997	(See para TN.10.1 <b>Fee:</b> \$80.40	3 of explanatory notes to this <b>Benefit:</b> 75% = \$60.30	
ANAES ONLY F PERFO	PAYABLE FOR A	ARE BENEFITS ARE	19. THERAPEUTIC AND DIAGNOSTIC SERVIC
		ative Value Guide For Ana erformed In Association W	aesthesia - Medicare Benefits Are Only Payable For With An Eligible Service
		Subgroup 19. T	Therapeutic And Diagnostic Services

#### 19. THERAPEUTIC AND DIAGNOSTIC SERVICES

	SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia (4 basic units)
22002	(See para TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)
22007	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units)
22008	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient:  (a) when performed in association with the management of anaesthesia for the patient; and (b) other than a service to which item 13876 applies (c) is categorised as having a high risk of complications or during the procedure develops either complications or a high risk of complications (3 basic units)
22012	(See para TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	Central venous, pulmonary arterial, systemic arterial or cardiac intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient:  (a) when performed in association with the management of anaesthesia for the patient; and  (b) relating to another discrete operation on the same day for the patient; and  (c) other than a service to which item 13876 applies  (d) who is categorised as having a high risk of complications or develops during the current procedure either complications or a high risk of complications (3 basic units)
22014	(See para TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	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)
22015	(See para TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	CENTRAL VEIN CATHETERISATION by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (4 basic units)
22020	(See para TN.1.6, TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
22025	Intra-arterial cannulation when performed in association with the management of anaesthesia in a patient who: (a) is categorised as having a high risk of complications; or (b) develops a high risk of complications during the procedure (4 basic units)

#### 19. THERAPEUTIC AND DIAGNOSTIC SERVICES

ELIGIB	LE SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES
	(See para TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	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 post-operative pain management, not being a service to which 22036 applies (5 basic units)
22031	(See para TN.10.17 of explanatory notes to this Category) <b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	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)
22036	(See para TN.10.17 of explanatory notes to this Category) <b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	Perioperative introduction of a plexus or nerve block proximal to the lower leg or forearm for post operative pain management (2 basic units)
22041	(See para TN.10.17 of explanatory notes to this Category) <b>Fee:</b> \$40.20 <b>Benefit:</b> 75% = \$30.15 85% = \$34.20
	Introduction of a nerve block performed via a retrobulbar, peribulbar, or sub Tenon's approach, or other complex eye block, when administered by an anaesthetist perioperatively (1 basic units)
22042	(See para TN.10.8 of explanatory notes to this Category) <b>Fee:</b> \$20.10
	INTRA-OPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY - Monitoring in real time of the structure and function of the heart chambers, valves and surrounding structures, including assessment of blood flow, with appropriate permanent recording during procedures on the heart, pericardium or great vessels of the chest (not in association with items 55130, 55135 or 21936) (9 basic units)
22051	(See para TN.10.30 of explanatory notes to this Category) <b>Fee:</b> \$180.90 <b>Benefit:</b> 75% = \$135.70 85% = \$153.80
	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)
22055	(See para TN.10.10 of explanatory notes to this Category) <b>Fee:</b> \$241.20 <b>Benefit:</b> 75% = \$180.90 85% = \$205.05
	WHOLE BODY PERFUSION, CARDIAC BYPASS, where the heart-lung machine or equivalent is continuously operated by a medical perfusionist, other than a service associated with anaesthesia to which an item in Subgroup 21 applies. (20 basic units) (20 basic units)
22060	(See para TN.10.10, TN.10.3 of explanatory notes to this Category) <b>Fee:</b> \$402.00 <b>Benefit:</b> 75% = \$301.50 85% = \$341.70
	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)
22065	(See para TN.10.10 of explanatory notes to this Category) <b>Fee:</b> \$100.50
22075	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including
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#### 19. THERAPEUTIC AND DIAGNOSTIC SERVICES

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 TN.10.10 of explanatory notes to this Category)

**Fee:** \$301.50 **Benefit:** 75% = \$226.15 85% = \$256.30

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

## 20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 20. Administration Of Anaesthesia In Connection With A Dental Service
	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units)
22900	(See para TN.10.14 of explanatory notes to this Category) <b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units)
22905	(See para TN.10.14 of explanatory notes to this Category) <b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 21. Anaesthesia/Perfusion Time Units
	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA
	(a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or
	(b) perfusion performed in association with item 22060; or
	(c) for assistance at anaesthesia performed in association with items 25200 to 25205
	For a period of:
23010	

LLIGID	LE SERVICE 21. ANAEST RESIA/FERFUSION TIME UNITS
	(FIFTEEN MINUTES OR LESS) (1 basic units)  (See para TN.10.3 of explanatory notes to this Category)  Fee: \$20.10  Benefit: 75% = \$15.10  85% = \$17.10
	16 MINUTES TO 30 MINUTES (2 basic units)
23025	<b>Fee:</b> \$40.20 <b>Benefit:</b> 75% = \$30.15 85% = \$34.20
	31 MINUTES to 45 MINUTES (3 basic units)
23035	<b>Fee:</b> \$60.30 <b>Benefit:</b> 75% = \$45.25 85% = \$51.30
	46 MINUTES to 1:00 HOUR (4 basic units)
23045	<b>Fee:</b> \$80.40 <b>Benefit:</b> 75% = \$60.30 85% = \$68.35
	1:01 HOURS to 1:15 HOURS (5 basic units)
23055	<b>Fee:</b> \$100.50 <b>Benefit:</b> 75% = \$75.40 85% = \$85.45
	1:16 HOURS to 1:30 HOURS (6 basic units)
23065	<b>Fee:</b> \$120.60 <b>Benefit:</b> 75% = \$90.45 85% = \$102.55
	1:31 HOURS to 1:45 HOURS (7 basic units)
23075	<b>Fee:</b> \$140.70 <b>Benefit:</b> 75% = \$105.55 85% = \$119.60
	1:46 HOURS to 2:00 HOURS (8 basic units)
23085	<b>Fee:</b> \$160.80 <b>Benefit:</b> 75% = \$120.60 85% = \$136.70
	2:01 HOURS TO 2:10 HOURS (9 basic units)
23091	<b>Fee:</b> \$180.90 <b>Benefit:</b> 75% = \$135.70 85% = \$153.80
	2:11 HOURS TO 2:20 HOURS (10 basic units)
23101	<b>Fee:</b> \$201.00 <b>Benefit:</b> 75% = \$150.75 85% = \$170.85
	2:21 HOURS TO 2:30 HOURS (11 basic units)
23111	<b>Fee:</b> \$221.10 <b>Benefit:</b> 75% = \$165.85 85% = \$187.95
	2:31 HOURS TO 2:40 HOURS (12 basic units)
23112	<b>Fee:</b> \$241.20 <b>Benefit:</b> 75% = \$180.90 85% = \$205.05
	2:41 HOURS TO 2:50 HOURS (13 basic units)
23113	<b>Fee:</b> \$261.30 <b>Benefit:</b> 75% = \$196.00 85% = \$222.15
	2:51 HOURS TO 3:00 HOURS (14 basic units)
23114	<b>Fee:</b> \$281.40 <b>Benefit:</b> 75% = \$211.05 85% = \$239.20
	3:01 HOURS TO 3:10 HOURS (15 basic units)
23115	<b>Fee:</b> \$301.50 <b>Benefit:</b> 75% = \$226.15 85% = \$256.30

3:11 HOURS TO 3:20 HOURS (16 basic units)  Fee: \$321.60 Benefit: 75% = \$241.20 85% = \$273.40  3:21 HOURS TO 3:30 HOURS (17 basic units)  Fee: \$341.70 Benefit: 75% = \$256.30 85% = \$290.45  3:31 HOURS TO 3:40 HOURS (18 basic units)  Fee: \$361.80 Benefit: 75% = \$271.35 85% = \$307.55  3:41 HOURS TO 3:50 HOURS (19 basic units)	
3:21 HOURS TO 3:30 HOURS (17 basic units)  Fee: \$341.70 Benefit: 75% = \$256.30 85% = \$290.45  3:31 HOURS TO 3:40 HOURS (18 basic units)  Fee: \$361.80 Benefit: 75% = \$271.35 85% = \$307.55	
23117 <b>Fee:</b> \$341.70 <b>Benefit:</b> 75% = \$256.30 85% = \$290.45  3:31 HOURS TO 3:40 HOURS (18 basic units) <b>Fee:</b> \$361.80 <b>Benefit:</b> 75% = \$271.35 85% = \$307.55	
3:31 HOURS TO 3:40 HOURS (18 basic units)  Fee: \$361.80 Benefit: 75% = \$271.35 85% = \$307.55	
23118 <b>Fee:</b> \$361.80 <b>Benefit:</b> 75% = \$271.35 85% = \$307.55	
3:41 HOURS TO 3:50 HOURS (19 basic units)	
23119 <b>Fee:</b> \$381.90 <b>Benefit:</b> 75% = \$286.45 85% = \$324.65	
3:51 HOURS TO 4:00 HOURS (20 basic units)	
23121 <b>Fee:</b> \$402.00 <b>Benefit:</b> 75% = \$301.50 85% = \$341.70	
4:01 HOURS TO 4:10 HOURS (21 basic units)	
23170 <b>Fee:</b> \$422.10 <b>Benefit:</b> 75% = \$316.60 85% = \$358.80	
4:11 HOURS TO 4:20 HOURS (22 basic units)	
23180 <b>Fee:</b> \$442.20 <b>Benefit:</b> 75% = \$331.65 85% = \$375.90	
4:21 HOURS TO 4:30 HOURS (23 basic units)	
<b>Fee:</b> \$462.30 <b>Benefit:</b> 75% = \$346.75 85% = \$393.00	
4:31 HOURS TO 4:40 HOURS (24 basic units)	
23200 <b>Fee:</b> \$482.40 <b>Benefit:</b> 75% = \$361.80 85% = \$410.05	
4:41 HOURS TO 4:50 HOURS (25 basic units)	
23210 <b>Fee:</b> \$502.50 <b>Benefit:</b> 75% = \$376.90 85% = \$427.15	
4:51 HOURS TO 5:00 HOURS (26 basic units)	
23220 <b>Fee:</b> \$522.60 <b>Benefit:</b> 75% = \$391.95 85% = \$444.25	
5:01 HOURS TO 5:10 HOURS (27 basic units)	
23230 <b>Fee:</b> \$542.70 <b>Benefit:</b> 75% = \$407.05 85% = \$461.30	
5:11 HOURS TO 5:20 HOURS (28 basic units)	
23240 <b>Fee:</b> \$562.80 <b>Benefit:</b> 75% = \$422.10 85% = \$478.40	
5:21 HOURS TO 5:30 HOURS (29 basic units)	
23250 <b>Fee:</b> \$582.90 <b>Benefit:</b> 75% = \$437.20 85% = \$498.20	
5:31 HOURS TO 5:40 HOURS (30 basic units)	
23260 <b>Fee:</b> \$603.00 <b>Benefit:</b> 75% = \$452.25 85% = \$518.30	

ELIGIB	LE SERVICE		21. ANAESTHESIA/PERFUSION TIME UNITS
	5:41 HOURS T	O 5:50 HOURS (31 basic unit	ts)
23270	Fee: \$623.10	<b>Benefit:</b> 75% = \$467.35	85% = \$538.40
	(5:51 HOURS	ΓΟ 6:00 HOURS (32 basic uni	its)
23280	Fee: \$643.20	<b>Benefit:</b> 75% = \$482.40	85% = \$558.50
	6:01 HOURS T	O 6:10 HOURS (33 basic unit	ts)
23290	Fee: \$663.30	<b>Benefit:</b> 75% = \$497.50	85% = \$578.60
	6:11 HOURS T	O 6:20 HOURS (34 basic unit	is)
23300	Fee: \$683.40	<b>Benefit:</b> 75% = \$512.55	85% = \$598.70
	6:21 HOURS T	O 6:30 HOURS (35 basic unit	is)
23310	Fee: \$703.50	<b>Benefit:</b> 75% = \$527.65	85% = \$618.80
	6:31 HOURS T	O 6:40 HOURS (36 basic unit	is)
23320	Fee: \$723.60	<b>Benefit:</b> 75% = \$542.70	85% = \$638.90
	6:41 HOURS T	O 6:50 HOURS (37 basic unit	ts)
23330	<b>Fee:</b> \$743.70	<b>Benefit:</b> 75% = \$557.80	85% = \$659.00
	6:51 HOURS T	O 7:00 HOURS (38 basic unit	ts)
23340	Fee: \$763.80	<b>Benefit:</b> 75% = \$572.85	85% = \$679.10
	7:01 HOURS T	O 7:10 HOURS (39 basic unit	is)
23350	Fee: \$783.90	<b>Benefit:</b> 75% = \$587.95	85% = \$699.20
	7:11 HOURS T	O 7:20 HOURS (40 basic unit	ts)
23360	Fee: \$804.00	<b>Benefit:</b> 75% = \$603.00	85% = \$719.30
	7:21 HOURS T	O 7:30 HOURS (41 basic unit	ts)
23370	Fee: \$824.10	<b>Benefit:</b> 75% = \$618.10	85% = \$739.40
	7:31 HOURS T	O 7:40 HOURS (42 basic unit	is)
23380		<b>Benefit:</b> 75% = \$633.15	
	7:41 HOURS T	O 7:50 HOURS (43 basic unit	is)
23390	Fee: \$864.30	<b>Benefit:</b> 75% = \$648.25	
	7:51 HOURS T	O 8:00 HOURS (44 basic unit	is)
23400	Fee: \$884.40	<b>Benefit:</b> 75% = \$663.30	
	8:01 HOURS T	O 8:10 HOURS (45 basic unit	is)
23410	Fee: \$904.50	<b>Benefit:</b> 75% = \$678.40	85% = \$819.80

ELIGIB	LE SERVICE		21. ANAEST HESIA/PERFUSION TIME UNITS
	8:11 HOURS TO	8:20 HOURS (46 basic uni	ts)
23420	Fee: \$924.60	<b>Benefit:</b> 75% = \$693.45	85% = \$839.90
	8:21 HOURS TO	8:30 HOURS (47 basic uni	ts)
23430	<b>Fee:</b> \$944.70	<b>Benefit:</b> 75% = \$708.55	85% = \$860.00
	8:31 HOURS TO	8:40 HOURS (48 basic uni	ts)
23440	Fee: \$964.80	<b>Benefit:</b> 75% = \$723.60	85% = \$880.10
	8:41 HOURS TO	8:50 HOURS (49 basic uni	ts)
23450	Fee: \$984.90	<b>Benefit:</b> 75% = \$738.70	85% = \$900.20
	8:51 HOURS TO	9:00 HOURS (50 basic uni	ts)
23460	Fee: \$1,005.00	<b>Benefit:</b> 75% = \$753.75	85% = \$920.30
	9:01 HOURS TO	9:10 HOURS (51 basic uni	ts)
23470	<b>Fee:</b> \$1,025.10	<b>Benefit:</b> 75% = \$768.85	85% = \$940.40
	9:11 HOURS TO	9:20 HOURS (52 basic uni	ts)
23480	Fee: \$1,045.20	<b>Benefit:</b> 75% = \$783.90	85% = \$960.50
	9:21 HOURS TO	9:30 HOURS (53 basic uni	ts)
23490	<b>Fee:</b> \$1,065.30	<b>Benefit:</b> 75% = \$799.00	85% = \$980.60
	9:31 HOURS TO	9:40 HOURS (54 basic uni	ts)
23500	Fee: \$1,085.40	<b>Benefit:</b> 75% = \$814.05	85% = \$1000.70
	9:41 HOURS TO	9:50 HOURS (55 basic uni	ts)
23510	<b>Fee:</b> \$1,105.50	<b>Benefit:</b> 75% = \$829.15	85% = \$1020.80
	9:51 HOURS TO	0 10:00 HOURS (56 basic ur	nits)
23520	Fee: \$1,125.60	<b>Benefit:</b> 75% = \$844.20	85% = \$1040.90
	10:01 HOURS T	O 10:10 HOURS (57 basic t	units)
23530	Fee: \$1,145.70	<b>Benefit:</b> 75% = \$859.30	85% = \$1061.00
	10:11 HOURS T	O 10:20 HOURS (58 basic 1	units)
23540	<b>Fee:</b> \$1,165.80	<b>Benefit:</b> 75% = \$874.35	85% = \$1081.10
	10:21 HOURS T	O 10:30 HOURS (59 basic t	units)
23550	Fee: \$1,185.90	<b>Benefit:</b> 75% = \$889.45	85% = \$1101.20
	10:31 HOURS T	O 10:40 HOURS (60 basic t	units)
23560	Fee: \$1,206.00	<b>Benefit:</b> 75% = \$904.50	85% = \$1121.30

LLIGIB	LL SLIVICL		21. ANALSTILSIA/FLIXI OSION TIME UNITS
	10:41 HOURS TO	O 10:50 HOURS (61 basic ur	nits)
23570	Fee: \$1,226.10	<b>Benefit:</b> 75% = \$919.60	85% = \$1141.40
	10:51 HOURS TO	O 11:00 HOURS (62 basic ur	nits)
23580	Fee: \$1,246.20	<b>Benefit:</b> 75% = \$934.65	85% = \$1161.50
	11:01 HOURS TO	O 11:10 HOURS (63 basic ur	nits)
23590	Fee: \$1,266.30	<b>Benefit:</b> 75% = \$949.75	85% = \$1181.60
	11:11 HOURS TO	O 11:20 HOURS (64 basic ur	nits)
23600	Fee: \$1,286.40	<b>Benefit:</b> 75% = \$964.80	85% = \$1201.70
	11:21 HOURS TO	O 11:30 HOURS (65 basic un	nits)
23610	<b>Fee:</b> \$1,306.50	<b>Benefit:</b> 75% = \$979.90	85% = \$1221.80
	11:31 HOURS TO	O 11:40 HOURS (66 basic ur	nits)
23620	Fee: \$1,326.60	<b>Benefit:</b> 75% = \$994.95	85% = \$1241.90
	11:41 HOURS T	O 11:50 HOURS (67 basic ur	nits)
23630	<b>Fee:</b> \$1,346.70	<b>Benefit:</b> 75% = \$1010.05	85% = \$1262.00
	11:51 HOURS TO	O 12:00 HOURS (68 basic ur	nits)
23640	Fee: \$1,366.80	<b>Benefit:</b> 75% = \$1025.10	85% = \$1282.10
	12:01 HOURS T	O 12:10 HOURS (69 basic ur	nits)
23650	Fee: \$1,386.90	<b>Benefit:</b> 75% = \$1040.20	85% = \$1302.20
	12:11 HOURS T	O 12:20 HOURS (70 basic ur	nits)
23660	Fee: \$1,407.00	<b>Benefit:</b> 75% = \$1055.25	85% = \$1322.30
	12:21 HOURS T	O 12:30 HOURS (71 basic ur	nits)
23670	Fee: \$1,427.10	<b>Benefit:</b> 75% = \$1070.35	85% = \$1342.40
	12:31 HOURS TO	O 12:40 HOURS (72 basic ui	nits)
23680	Fee: \$1,447.20	<b>Benefit:</b> 75% = \$1085.40	85% = \$1362.50
	12:41 HOURS TO	O 12:50 HOURS (73 basic ur	nits)
23690	Fee: \$1,467.30	<b>Benefit:</b> 75% = \$1100.50	85% = \$1382.60
	12:51 HOURS TO	O 13:00 HOURS (74 basic ur	nits)
23700	Fee: \$1,487.40	<b>Benefit:</b> 75% = \$1115.55	85% = \$1402.70
	13:01 HOURS T	O 13:10 HOURS (75 basic ur	nits)
23710	<b>Fee:</b> \$1,507.50	<b>Benefit:</b> 75% = \$1130.65	85% = \$1422.80

LLIGID	LL SLKVICL		21. ANALSTITESIA/FERT USION TIME UNITS
	13:11 HOURS TO	O 13:20 HOURS (76 basic ui	nits)
23720	Fee: \$1,527.60	<b>Benefit:</b> 75% = \$1145.70	85% = \$1442.90
	13:21 HOURS TO	O 13:30 HOURS (77 basic ui	nits)
23730	<b>Fee:</b> \$1,547.70	<b>Benefit:</b> 75% = \$1160.80	85% = \$1463.00
	13:31 HOURS TO	O 13:40 HOURS (78 basic ui	nits)
23740	Fee: \$1,567.80	<b>Benefit:</b> 75% = \$1175.85	85% = \$1483.10
	13:41 HOURS TO	O 13:50 HOURS (79 basic un	nits)
23750	<b>Fee:</b> \$1,587.90	<b>Benefit:</b> 75% = \$1190.95	85% = \$1503.20
	13:51 HOURS TO	O 14:00 HOURS (80 basic un	nits)
23760	Fee: \$1,608.00	<b>Benefit:</b> 75% = \$1206.00	85% = \$1523.30
	14:01 HOURS TO	D 14:10 HOURS (81 basic u	nits)
23770	Fee: \$1,628.10	<b>Benefit:</b> 75% = \$1221.10	85% = \$1543.40
	14:11 HOURS TO	O 14:20 HOURS (82 basic un	nits)
23780	Fee: \$1,648.20	<b>Benefit:</b> 75% = \$1236.15	85% = \$1563.50
	14:21 HOURS TO	O 14:30 HOURS (83 basic un	nits)
23790	Fee: \$1,668.30	<b>Benefit:</b> 75% = \$1251.25	85% = \$1583.60
	14:31 HOURS TO	O 14:40 HOURS (84 basic un	nits)
23800	Fee: \$1,688.40	<b>Benefit:</b> 75% = \$1266.30	85% = \$1603.70
	14:41 HOURS TO	O 14:50 HOURS (85 basic un	nits)
23810	Fee: \$1,708.50	<b>Benefit:</b> 75% = \$1281.40	85% = \$1623.80
	14:51 HOURS TO	O 15:00 HOURS (86 basic un	nits)
23820	Fee: \$1,728.60	<b>Benefit:</b> 75% = \$1296.45	85% = \$1643.90
	15:01 HOURS TO	D 15:10 HOURS (87 basic ui	nits)
23830	Fee: \$1,748.70	<b>Benefit:</b> 75% = \$1311.55	85% = \$1664.00
	15:11 HOURS TO	O 15:20 HOURS (88 basic ui	nits)
23840	Fee: \$1,768.80	<b>Benefit:</b> 75% = \$1326.60	85% = \$1684.10
	15:21 HOURS TO	O 15:30 HOURS (89 basic ui	nits)
23850	Fee: \$1,788.90	<b>Benefit:</b> 75% = \$1341.70	
	15:31 HOURS TO	O 15:40 HOURS (90 basic un	nits)
23860	Fee: \$1,809.00	<b>Benefit:</b> 75% = \$1356.75	85% = \$1724.30

LLIGID	LL SLKVICL		21. ANALSTITESIA/FERT OSION TIME UNITS
	15:41 HOURS TO	O 15:50 HOURS (91 basic u	nits)
23870	Fee: \$1,829.10	<b>Benefit:</b> 75% = \$1371.85	85% = \$1744.40
	15:51 HOURS TO	O 16:00 HOURS (92 basic ui	nits)
23880	Fee: \$1,849.20	<b>Benefit:</b> 75% = \$1386.90	85% = \$1764.50
	16:01 HOURS TO	O 16:10 HOURS (93 basic un	nits)
23890	<b>Fee:</b> \$1,869.30	<b>Benefit:</b> 75% = \$1402.00	85% = \$1784.60
	16:11 HOURS TO	O 16:20 HOURS (94 basic ui	nits)
23900	Fee: \$1,889.40	<b>Benefit:</b> 75% = \$1417.05	85% = \$1804.70
	16:21 HOURS TO	O 16:30 HOURS (95 basic un	nits)
23910	Fee: \$1,909.50	<b>Benefit:</b> 75% = \$1432.15	85% = \$1824.80
	16:31 HOURS TO	O 16:40 HOURS (96 basic ui	nits)
23920	Fee: \$1,929.60	<b>Benefit:</b> 75% = \$1447.20	85% = \$1844.90
	16:41 HOURS TO	O 16:50 HOURS (97 basic ui	nits)
23930	<b>Fee:</b> \$1,949.70	<b>Benefit:</b> 75% = \$1462.30	85% = \$1865.00
	16:51 HOURS TO	O 17:00 HOURS (98 basic ui	nits)
23940	Fee: \$1,969.80	<b>Benefit:</b> 75% = \$1477.35	85% = \$1885.10
	17:01 HOURS TO	O 17:10 HOURS (99 basic ui	nits)
23950	Fee: \$1,989.90	<b>Benefit:</b> 75% = \$1492.45	85% = \$1905.20
	17:11 HOURS TO	D 17:20 HOURS (100 basic t	units)
23960	Fee: \$2,010.00	<b>Benefit:</b> 75% = \$1507.50	85% = \$1925.30
	17:21 HOURS TO	D 17:30 HOURS (101 basic t	units)
23970	Fee: \$2,030.10	<b>Benefit:</b> 75% = \$1522.60	85% = \$1945.40
	17:31 HOURS TO	D 17:40 HOURS (102 basic t	units)
23980	Fee: \$2,050.20	<b>Benefit:</b> 75% = \$1537.65	85% = \$1965.50
	17:41 HOURS TO	D 17:50 HOURS (103 basic t	units)
23990	Fee: \$2,070.30	<b>Benefit:</b> 75% = \$1552.75	85% = \$1985.60
	17:51 HOURS TO	D 18:00 HOURS (104 basic t	units)
24100	Fee: \$2,090.40	<b>Benefit:</b> 75% = \$1567.80	85% = \$2005.70
	18:01 HOURS TO	D 18:10 HOURS (105 basic t	units)
24101	Fee: \$2,110.50	<b>Benefit:</b> 75% = \$1582.90	85% = \$2025.80

ELIGID	LE SERVICE	21. ANAESTHESIA/PERFUSION TIME UNITS
	18:11 HOURS TO 18:20 HOURS (106 basi	c units)
24102	<b>Fee:</b> \$2,130.60 <b>Benefit:</b> 75% = \$1597.9	95 85% = \$2045.90
	18:21 HOURS TO 18:30 HOURS (107 basis	c units)
24103	<b>Fee:</b> \$2,150.70 <b>Benefit:</b> 75% = \$1613.0	05 85% = \$2066.00
	18:31 HOURS TO 18:40 HOURS (108 basi	c units)
24104	<b>Fee:</b> \$2,170.80 <b>Benefit:</b> 75% = \$1628.1	0 85% = \$2086.10
	18:41 HOURS TO 18:50 HOURS (109 basi	c units)
24105	<b>Fee:</b> \$2,190.90 <b>Benefit:</b> 75% = \$1643.2	20 85% = \$2106.20
	18:51 HOURS TO 19:00 HOURS (110 basi	c units)
24106	<b>Fee:</b> \$2,211.00 <b>Benefit:</b> 75% = \$1658.2	25 85% = \$2126.30
	19:01 HOURS TO 19:10 HOURS (111 basi	c units)
24107	<b>Fee:</b> \$2,231.10 <b>Benefit:</b> 75% = \$1673.3	35 85% = \$2146.40
	19:11 HOURS TO 19:20 HOURS (112 basi	c units)
24108	<b>Fee:</b> \$2,251.20 <b>Benefit:</b> 75% = \$1688.4	.0 85% = \$2166.50
	19:21 HOURS TO 19:30 HOURS (113 basis	c units)
24109	<b>Fee:</b> \$2,271.30 <b>Benefit:</b> 75% = \$1703.5	0 85% = \$2186.60
	19:31 HOURS TO 19:40 HOURS (114 basi	c units)
24110	<b>Fee:</b> \$2,291.40 <b>Benefit:</b> 75% = \$1718.5	5 85% = \$2206.70
	19:41 HOURS TO 19:50 HOURS (115 basis	c units)
24111	<b>Fee:</b> \$2,311.50 <b>Benefit:</b> 75% = \$1733.6	55 85% = \$2226.80
	19:51 HOURS TO 20:00 HOURS (116 basi	c units)
24112	<b>Fee:</b> \$2,331.60 <b>Benefit:</b> 75% = \$1748.7	0 85% = \$2246.90
	20:01 HOURS TO 20:10 HOURS (117 basi	c units)
24113	<b>Fee:</b> \$2,351.70 <b>Benefit:</b> 75% = \$1763.8	30 85% = \$2267.00
	20:11 HOURS TO 20:20 HOURS (118 basi	c units)
24114	<b>Fee:</b> \$2,371.80 <b>Benefit:</b> 75% = \$1778.8	35 85% = \$2287.10
	20:21 HOURS TO 20:30 HOURS (119 basi	c units)
24115	<b>Fee:</b> \$2,391.90 <b>Benefit:</b> 75% = \$1793.9	25 85% = \$2307.20
	20:31 HOURS TO 20:40 HOURS (120 basi	c units)
24116	<b>Fee:</b> \$2,412.00 <b>Benefit:</b> 75% = \$1809.0	0 85% = \$2327.30

	LL SLIVICL		ZI. ANALSTIILSIA/FLIN USION TIML UNITS
	20:41 HOURS T	O 20:50 HOURS (121 basic t	units)
24117	<b>Fee:</b> \$2,432.10	<b>Benefit:</b> 75% = \$1824.10	85% = \$2347.40
	20:51 HOURS T	O 21:00 HOURS (122 basic t	units)
24118	Fee: \$2,452.20	<b>Benefit:</b> 75% = \$1839.15	85% = \$2367.50
	21:01 HOURS T	O 21:10 HOURS (123 basic u	ınits)
24119	Fee: \$2,472.30	<b>Benefit:</b> 75% = \$1854.25	85% = \$2387.60
	21:11 HOURS T	O 21:20 HOURS (124 basic t	units)
24120	<b>Fee:</b> \$2,492.40	<b>Benefit:</b> 75% = \$1869.30	85% = \$2407.70
	21:21 HOURS T	O 21:30 HOURS (125 basic u	units)
24121	<b>Fee:</b> \$2,512.50	<b>Benefit:</b> 75% = \$1884.40	85% = \$2427.80
	21:31 HOURS T	O 21:40 HOURS (126 basic t	units)
24122	<b>Fee:</b> \$2,532.60	<b>Benefit:</b> 75% = \$1899.45	85% = \$2447.90
	21:41 HOURS T	O 21:50 HOURS (127 basic t	units)
24123	<b>Fee:</b> \$2,552.70	<b>Benefit:</b> 75% = \$1914.55	85% = \$2468.00
	21:51 HOURS T	O 22:00 HOURS (128 basic t	units)
24124	<b>Fee:</b> \$2,572.80	<b>Benefit:</b> 75% = \$1929.60	85% = \$2488.10
	22:01 HOURS T	O 22:10 HOURS (129 basic t	units)
24125	<b>Fee:</b> \$2,592.90	<b>Benefit:</b> 75% = \$1944.70	85% = \$2508.20
	22:11 HOURS T	O 22:20 HOURS (130 basic t	units)
24126	<b>Fee:</b> \$2,613.00	<b>Benefit:</b> 75% = \$1959.75	85% = \$2528.30
	22:21 HOURS T	O 22:30 HOURS (131 basic t	units)
24127	<b>Fee:</b> \$2,633.10	<b>Benefit:</b> 75% = \$1974.85	85% = \$2548.40
	22:31 HOURS T	O 22:40 HOURS (132 basic u	units)
24128	<b>Fee:</b> \$2,653.20	<b>Benefit:</b> 75% = \$1989.90	85% = \$2568.50
	22:41 HOURS T	O 22:50 HOURS (133 basic u	units)
24129	<b>Fee:</b> \$2,673.30	<b>Benefit:</b> 75% = \$2005.00	85% = \$2588.60
	22:51 HOURS T	O 23:00 HOURS (134 basic u	units)
24130	<b>Fee:</b> \$2,693.40	<b>Benefit:</b> 75% = \$2020.05	85% = \$2608.70
	23:01 HOURS T	O 23:10 HOURS (135 basic t	units)
24131	<b>Fee:</b> \$2,713.50	<b>Benefit:</b> 75% = \$2035.15	85% = \$2628.80

#### 21. ANAESTHESIA/PERFUSION TIME UNITS

	23:11 HOURS TO 23:20 HOURS (136 basic units)		
24132	Fee: \$2,733.60	<b>Benefit:</b> 75% = \$2050.20 85% = \$2648.90	
	23:21 HOURS TO	O 23:30 HOURS (137 basic units)	
24133	Fee: \$2,753.70	<b>Benefit:</b> 75% = \$2065.30 85% = \$2669.00	
	23:31 HOURS TO	O 23:40 HOURS (138 basic units)	
24134	Fee: \$2,773.80	<b>Benefit:</b> 75% = \$2080.35 85% = \$2689.10	
	23:41 HOURS TO	O 23:50 HOURS (139 basic units)	
24135	Fee: \$2,793.90	<b>Benefit:</b> 75% = \$2095.45 85% = \$2709.20	
	23:51 HOURS TO	O 24:00 HOURS (140 basic units)	
24136	Fee: \$2,814.00	<b>Benefit:</b> 75% = \$2110.50 85% = \$2729.30	

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

## 22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS

ELIGIB	LE SERVICE UNITS - PHYSICAL STATUS
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 22. Anaesthesia/Perfusion Modifying Units - Physical Status
	ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA
	(a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or
	(b) for perfusion performed in association with item 22060; or
	(c) for assistance at anaesthesia performed in association with items 25200 to 25205
	Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units)
25000	(See para TN.10.3 of explanatory notes to this Category) <b>Fee:</b> \$20.10 <b>Benefit:</b> 75% = \$15.10  85% = \$17.10
	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 TN.10.3 of explanatory notes to this Category)
25005	<b>Fee:</b> \$40.20 <b>Benefit:</b> 75% = \$30.15 85% = \$34.20
	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units)
25010	(See para TN.10.3 of explanatory notes to this Category)

## 22. ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

**Fee:** \$60.30

## 23. ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service				
	Subgroup 23. Anaesthesia/Perfusion Modifying Units - Other				
	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is over 3 years of age but under 4 years of age (1 basic units)				
25012	<b>Fee:</b> \$20.10 <b>Benefit:</b> 75% = \$15.10 85% = \$17.10				
	Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged not more than 3 years or at least 75 years (1 basic units)				
25015	<b>Fee:</b> \$20.10 <b>Benefit:</b> 75% = \$15.10 85% = \$17.10				
	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 TN.10.3 of explanatory notes to this Category)					
25020	<b>Fee:</b> \$40.20 <b>Benefit:</b> 75% = \$30.15 85% = \$34.20				

**Benefit:** 75% = \$45.25 85% = \$51.30

#### T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN

### 24. ANAESTHESIA AFTER HOURS EMERGENCY

_	LE SERVICE MODIFIER
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 24. Anaesthesia After Hours Emergency Modifier
	EMERGENCY ANAESTHESIA performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25030 or 25050 applies (0 basic units)
25025	(See para TN.10.3 of explanatory notes to this Category) <b>Derived Fee:</b> 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

#### 24. ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER

	LE SERVICE	MODIFIER		
	the range 22001-22051			
	immediate treatment without which there wou than 50% of the time for which the assistant is the after hours period, being the period from 8	ENCY ANAESTHESIA where the patient requires ald be significant threat to life or body part and where more in professional attendance on the patient is provided in the sam on any weekday, or at any time on a Saturday, vice associated with a service to which item 25020, 25025		
25030	(See para TN.10.3 of explanatory notes to this Cate <b>Derived Fee:</b> An additional amount of 50% of th (a) an assistant anaesthesia item in the range 25200 (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000-2500 (d) where performed, any associated therapeutic or	e fee for assistance at anaesthesia. That is: 0 - 25205, plus 5015, plus		
ANAEST ONLY P PERFOR	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	25. PERFUSION AFTER HOURS EMERGENCY MODIFIER		
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service			
	Subgroup 25. Perfusion After Hours Emergency Modifier			
	AFTER HOURS EMERGENCY PERFUSION where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020, 25025 or 25030 applies (0 basic units)			
25050	(See para TN.10.3 of explanatory notes to this Cate <b>Derived Fee:</b> An additional amount of 50% of th (a) item 22060, plus (b) an item in the range 23010 - 24136, plus (c) where applicable, an item in the range 25000 - 2 (d) where performed, any associated therapeutic or	e fee for the perfusion service. That is:		
ANAEST ONLY P PERFOR	ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE	26. ASSISTANCE AT ANAESTHESIA		
	Group T10. Relative Value Guide For Anaes Anaesthesia Performed In Association With	sthesia - Medicare Benefits Are Only Payable For n An Eligible Service		
	Subgroup 26	S. Assistance At Anaesthesia		
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#### 26. ASSISTANCE AT ANAESTHESIA

ELIGIB	E SERVICE 26. ASSISTANCE AT ANAESTHESIA
	units)
	(See para TN.10.9 of explanatory notes to this Category) <b>Derived Fee:</b> An amount of \$100.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051
	ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA where:
	(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)
25205	(See para TN.10.9 of explanatory notes to this Category) <b>Derived Fee:</b> An amount of \$100.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable - an item in the range 25000 - 25020 plus, where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22051
T11. B0	TULINUM TOXIN INJECTIONS
	Group T11. Botulinum Toxin Injections
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day
18350	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15  85% = \$107.85
	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of hemifacial spasm in a patient who is at least 18 years of age, including all such injections on any one day
18351	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15 85% = \$107.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of cervical dystonia (spasmodic torticollis), including all such injections on any one day
18353	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$253.75 <b>Benefit:</b> 75% = \$190.35 85% = \$215.70
18354	Botulinum Toxin Type A Purified Neurotixin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport), injection of, for the treatment of dynamic equinus foot deformity (including equinovarus and equinovalgus) due to spasticity in an ambulant cerebral palsy

T11. BOT	ULINUM TOXIN INJECTIONS						
	patient, if:						
	(a) the patient is at least 2 years of age; and						
	(b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.)						
	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15  85% = \$107.85						
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), or Clostridium Botulinum Type A Toxin Haemagglutinin Complex (Dysport), injection of, for the treatment of moderate to severe focal spasticity, if:						
	(a) the patient is at least 18 years of age; and						
	(b) the spasticity is associated with a previously diagnosed neurological disorder; and						
	(c) treatment is provided as:						
	(i) second line therapy when standard treatment for the conditions has failed; or						
	(ii) an adjunct to physical therapy; and						
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each limb), including all injections per set; and						
	(e) the treatment is not provided on the same occasion as a service mentioned in item 18365						
18360	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15 85% = \$107.85						
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy if:						
	(a) the patient is at least 2 years of age, and						
	(b) for a patient who is at least 18 years of age - before the patient turned 18, the patient had commenced treatment for the spasticity with botulinum toxin supplied under the pharmaceutical benefits scheme; and						
	(c) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.)						
18361	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15 85% = \$107.85						
	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if:						
	(a) the patient is at least 12 years of age; and						
18362	(b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and						
10302							

T11. BOT	ULINUM TOXIN INJECTIONS					
	(c) the patient has not had treatment with botulinum toxin within the immediately preceding 4 months; and					
	(d) if the patient has had treatment with botulinum toxin within the previous 12 months - the patient had treatment on no more than 2 separate occasions (Anaes.)					
	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$250.65 <b>Benefit:</b> 75% = \$188.00 85% = \$213.10					
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox) or Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of moderate to severe spasticity of the upper limb following a stroke, if:					
	(a) the patient is at least 18 years of age; and					
	(b) treatment is provided as:					
	(i) second line therapy when standard treatment for the condition has failed; or					
	(ii) an adjunct to physical therapy; and					
	(c) the patient does not have established severe contracture in the limb that is to be treated; and					
	(d) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set; and					
	(e) for a patient who has received treatment on 2 previous separate occasions - the patient has responded to the treatment					
(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15  85% = \$107.85						
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.)					
18366	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$158.90 <b>Benefit:</b> 75% = \$119.20  85% = \$135.10					
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day					
18368	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$271.30 <b>Benefit:</b> 75% = \$203.50 85% = \$230.65					
	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)					
18369	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$45.75 <b>Benefit:</b> 75% = \$34.35 85% = \$38.90					
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)					
18370	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$45.75 <b>Benefit:</b> 75% = \$34.35  85% = \$38.90					
18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of					

	TULINUM TOXIN INJECTIONS  hilatoral blockerscores in a retient who is at least 12 years of against who is all each injections on any
	bilateral blepharospasm, in a patient who is at least 12 years of age; including all such injections on any one day (Anaes.)
	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15 85% = \$107.85
	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or IncobotulinumtoxinA (Xeomin), injection of, for the treatment of bilateral blepharospasm in a patient who is at least 18 years of age, including all such injections on any one day (Anaes.)
18374	(See para TN.11.1 of explanatory notes to this Category) <b>Fee:</b> \$126.85 <b>Benefit:</b> 75% = \$95.15  85% = \$107.85
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if:
	(a) the urinary incontinence is due to neurogenic detrusor overactivity as demonstrated by urodynamic study of a patient with:
	(i) multiple sclerosis; or
	(ii) spinal cord injury; or
	(iii) spina bifida and who is at least 18 years of age; and
	(b) the patient has urinary incontinence that is inadequately controlled by anti-cholinergic therapy, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin type A; and
	(c) the patient is willing and able to self-catheterise; and
	(d) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with; and
	(e) treatment is not provided on the same occasion as a service described in item 104, 105, 110, 116, 119, 11900 or 11919
18375	For each patient - applicable not more than once except if the patient achieves at least a 50% reduction in

#### T11. BOTULINUM TOXIN INJECTIONS urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (Anaes.) (See para TN.11.1 of explanatory notes to this Category) Fee: \$233.55 **Benefit:** 75% = \$175.20 Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of chronic migraine, including all injections in 1 day, if: the patient is at least 18 years of age; and (b) the patient has experienced an inadequate response, intolerance or contraindication to at least 3 prophylactic migraine medications before commencement of treatment with botulinum toxin, as manifested by an average of 15 or more headache days per month, with at least 8 days of migraine, over a period of at least 6 months, before commencement of treatment with botulinum toxin; and (c) the requirements relating to botulinum toxin type A under the Pharmaceutical Benefits Scheme are complied with For each patient-applicable not more than twice except if the patient achieves and maintains at least a 50% reduction in the number of headache days per month from baseline after 2 treatment cycles (each of 12 weeks duration) (See para TN.11.1 of explanatory notes to this Category) **Benefit:** 75% = \$95.15 85% = \$107.85 18377 **Fee:** \$126.85 Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), intravesical injection of, with cystoscopy, for the treatment of urinary incontinence, including all such injections on any one day, if: the urinary incontinence is due to idiopathic overactive bladder in a patient: and the patient is at least 18 years of age; and the patient has urinary incontinence that is inadequately controlled by at least 2 alternative anticholinergic agents, as manifested by having experienced at least 14 episodes of urinary incontinence per week before commencement of treatment with botulinum toxin; and the patient is willing and able to self-catheterise; and treatment is not provided on the same occasion as a service mentioned in item 104, 105, 110, 116, 119, 11900 or 11919 For each patient-applicable not more than once except if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline at any time during the period of 6 to 12 weeks after first treatment (H) (Anaes.) (See para TN.11.1 of explanatory notes to this Category) 18379 Fee: \$233.55 **Benefit:** 75% = \$175.20

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with cystoscopy and injection for incontinence	37339		
with debulking operation	35720		
with dilatation of tracheal stricture	41904		
with division of extensive adhesions	30379		
with drainage of pus	31454		
with insertion of cochlear implant	41617		
with insertion of portacath	30400		
with laparotomy, neonatal anorectal malformation			
with laparotomy, not with hysterectomy	35713, 35717		
with laryngoplasty or tracheoplasty	41879		
with laser destruction of stone	37318		
with other procedures	35644-35647		
with ovarian transposition, malignancy	35729		
with proctocolectomy	32015		
with removal of cartilage and/or bone	41512, 41515		
	6, 41822, 41825		
with supraglottic laryngectomy	41840		
with surgical repositioning of nipple	45520, 45523		
with total colectomy	32009		
with transbronchial lung biopsy	41898		
with transection/resection Fallopian tubes	35688		
with transmastoid removal of glomus tumour	41623		
	35673		
with vaginal hysterectomy			
with vertical hemi-laryngectomy	41837		
without surgical repositioning of nipple	45522		
Wolfe graft	45451		