Australian Government Department of Health

Medicare Benefits Schedule Book Category 3 Operating from 1 March 2021

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.0.1 AskMBS Email Advice Service

AskMBS responds to enquiries from providers of services listed on the Medicare Benefits Schedule (MBS) seeking advice on interpretation of MBS items (including those for dental, pathology and diagnostic imaging), explanatory notes and associated legislation. This advice is intended primarily to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. AskMBS works closely with policy areas within the Department of Health, and with Services Australia, to ensure enquirers receive accurate, authoritative and up-to-date information.

If you have a query relating exclusively to interpretation of the Schedule, you should email askMBS@health.gov.au.

If you are seeking advice in relation to Medicare billing, claiming, payments or obtaining a provider number, please contact Services Australia on the Provider Enquiry Line on 13 21 50.

AskMBS issues advisories summarising responses to frequently asked questions on specific subject areas. AskMBS Email Advice Service

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 Services Australia

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Services Australia.

Changes to Provider Contact Details

It is important that you contact Services Australia 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 Services Australia at:

Medicare

GPO Box 9822

in your capital city

or

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

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

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

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

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

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

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

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

How to apply for vocational recognition

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

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

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

Continued vocational recognition is dependent upon:

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

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

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

Removal of vocational recognition status

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

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

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

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

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

The Department of Human Services (DHS) has developed an <u>Health Practitioner Guideline to substantiate that a</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.5.16 Conjoint Committee for recognising training in Micro Bypass Glaucoma Surgery (MBGS)

The Conjoint Committee comprises representatives from the Australian and New Zealand Glaucoma Society (ANZGS) and the Royal Australian and New Zealand College of Ophthalmologists (RANZCO). For the purposes of MBS item 42504, specialists performing this procedure must have certification and training recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery, and the Department of Human Services notified of that recognition.

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.0.6** 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.

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

Additional Information

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

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

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

(i) a reprimand;

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

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

GN.8.19 Medicare Participation Review Committee

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

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

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

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

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

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

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

GN.8.21 Comprehensive Management Framework for the MBS

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

GN.8.22 Medical Services Advisory Committee

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

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

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

GN.8.23 Pathology Services Table Committee

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

GN.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 2021 is \$481.20. 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 2021, 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 \$697.00. The threshold for all other singles and families in 2021 is \$2,184.30.

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

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

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 essential assistance is provided, according to accepted medical practice:-

- (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, 11705, 11724, 11728, 11729, 11730, 11731, 11921, 12000, 12003;
- (c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13750-13760, 13950, 14050, 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 (with the exception of COVID-19 telehealth services);
- (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;
- (l) transmyocardial laser revascularisation;
- (m) vertebral axial decompression therapy, for chronic back pain;
- (n) autologous chondrocyte implantation and matrix-induced autologous chondrocyte implantation;
- (o) vertebroplasty;
- (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 01/03/2021

The 01/03/2021 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:

	(b) (c) (d)	(a) new item(b) amended description(c) fee amended(d) item number changed(e) EMSN changed					New Amend Fee Renum EMSN					
Deleted 30696	d Items 30710	41889	41892	41895	41898	41901	41905					
New Ite 38416	e ms 38417	38419	38420	38422	38423	38425	38426	45658				
Descrip 15900 35582	ption Ai 22060 35585	mended 30196 42739	30202	31516	32223	32224	32226	35570	35571	35573	35577	35581

Fee Amended

22060 30630

New item for correction of congenital deformity of the ear

A new item 45658 is being introduced for the correction of a congenital deformity of the ear in patients of any age. Currently only patients who are under 18 years of age are able to access a Medicare service (item 45659) for the correction of congenital deformity of the ear.

Amendment to Targeted Intraoperative Radiotherapy Item 15900 and 31516

Amendment to MBS items 15900 and 31516 for targeted intraoperative radiation therapy to enable this service to be provided by using the Xoft® Axxent® device. Targeted intraoperative radiation therapy is usually delivered as part of a breast conserving surgical procedure and is an alternative treatment option for breast cancer patients. In items 15900 and 31516 the word 'radiotherapy' to be replaced with 'radiation therapy' and both items will include 'Applicable only once per breast per lifetime'.

Fee change to item 30630 to reflect MBS review recommendation

From 1 March 2021, a change to MBS item 30630, insertion of a testicular prosthesis, where the prosthesis is inserted at least six months after an orchidectomy will see an increase in the MBS schedule fee to \$488.55.

The change is being made following item 30630 commencing on 1 November 2020 which had an incorrect fee listed. The service provided under item 30630 is intended to replace the service from being claimed under item 45051, which is for the contour reconstruction for open repair of contour defects, due to deformity, where the insertion of a non-biological implant is required.

Subsequent changes to items for transvaginal repair of pelvic organ prolapse (excision of graft material)

Seven items 33570, 35571, 35573, 35577, 35581, 35582 and 35585 from the *Health Insurance (Section 3C General Medical Services—Transvaginal repair of pelvic organ prolapse and procedures for the excision of graft material) Determination 2018* will be incorporated into the GMST.

Cardio Thoracic

From 1 March 2021, eight diagnostic and therapeutic procedures of the lung, tranche and bronchus items are being relocated from subgroups 1 and 8 of group T8 to subgroup 6 to better reflect the type and nature of these services. The following items will be ceased and replaced with new item numbers:

Ceased items	30696	30710	41889	41892	41895	41898	41901	41905
New items	38416	38417	38419	38420	38422	38423	38425	38426

Amendment of colonoscopy items 32223, 32224 and 32226

As of 1 March 2021, changes will be made to colonoscopy item numbers 32223, 32224 and 32226 to better reflect the clinical indications for colonoscopy. These changes follow extensive feedback from and consultation with key stakeholders.

Amendment to anaesthesia item 22060

The fee for item 22060 (whole body perfusion, cardiac bypass) will be increased by 50 percent as of 1 March 2020 following feedback from and negotiation with key stakeholders.

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.1.9 Intensive Care Units - (Items 13870 to 13888) 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 respiratory failure for at least 24 hours; and
- (ii) invasive cardiovascular monitoring; and
- (b) is supported by:
- (i) at least one specialist 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, provided suitable cover is available. Outside normal working hours the specialist must be immediately contactable and, if required, available to return to the ICU within a reasonable time.

"exclusively rostered" means that the specialist's sole clinical commitment is to intensive care.

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 13815, 13818, 13832, 13834, 13835, 13837, 13838, 13840, 13842, 13848, 13851, 13854 and 13857)

TN.1.10 Procedures Associated with Intensive Care - (Items 13815, 13818, 13832, 13834, 13835, 13837, 13838, 13840, 13842, 13848, 13851, 13854 and 13857)

Item 13815 covers the insertion of a central vein catheter, including under ultrasound guidance where clinically appropriate. No separate ultrasound item is payable with item 13815.

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

Items 13832, 13834, 13835, 13837, 13838 and 13840

These items cover extracorporeal life support services in an ICU. Benefits are payable only once per calendar day for a patient, irrespective of the number of medical practitioners involved.

Items 13832 and 13840 include the use of ultrasound guidance where clinically appropriate. No separate ultrasound item is payable with these items.

Item 13839

Provides for collection of blood for diagnostic purposes by arterial puncture.

Medicare benefits are not payable for sampling by arterial puncture under item 13839 in addition to item 13870 and 13873 on the same day.

Item 13842

This item provides for intra-arterial cannulation (including ultrasound guidance) for either or both intra-arterial pressure monitoring or blood sampling.

If a service covered by item 13842 is provided outside of an ICU, in association with, for example, an anaesthetic, benefits are payable under item 13842 in addition to item 13870 and 13873 when performed on the same day.

Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against item 13842.

Item 13848

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

Items 13851 and 13854

Items 13851 and 13854 cover the management of ventricular assist devices in an ICU. Benefits are payable only once per calendar day per patient, irrespective of the number of medical practitioners involved.

Item 13851 covers management of ventricular assist devices on the first day where the ICU admission relates to the device implantation or complication. Management on each day subsequent to the first is covered under item 13854.

Item 13857

This item 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 utilised.

TN.1.11 Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876, 13888 and 13899)

TN.1.11 Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876, 13888 and 13899)

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 intensive care specialist 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 within 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.

Item 13899

Item 13899 covers the discussion and documentation of goals of care for a gravely ill patient lacking current goals of care by an intensive care specialist outside an Intensive Care Unit. Benefits are paid only once per patient admission (including instances of use of corresponding emergency medicine goals of care items 5039, 5041, 5042 and 5044), unless precipitated by a subsequent ICU referral or Cardiac Arrest/Medical Emergency Team call where the clinical circumstances change substantively with a resultant expectation that the original goals of care require amendment.

Item 13899 cannot be co-claimed with item 13870 or 13873 on the same day.

Notes:

"gravely ill patient lacking current goals of care" and "preparation of goals of care" are defined in the General Medical Services Table.

"gravely ill patient lacking current goals of care" means a patient to whom all of the following apply:

- (a) the patient either:
 - (i) is suffering a life-threatening acute illness or injury; or
 - (ii) is suffering acute illness or injury and, apart from the illness or injury, has a high risk of dying within 12 months:
- (b) one or more alternatives to management of the illness or injury are clinically appropriate for the patient;

(c) either:

- (i) there is not a record of goals of care for the patient that can readily be retrieved by providers of health care for the patient and that identifies interventions that should, or should not, be made in care of the patient; or
- (ii) there is such a record but it is reasonable to expect that, due to changes in the patient's condition, the goals recorded will change substantially.

"preparation of goals of care" for a patient, by a medical practitioner, means the carrying out of all of the following activities by the practitioner:

- (a) comprehensively evaluating the patient's medical, physical, psychological and social issues;
- (b) identifying major issues that require goals of care for the patient to be set;
- (c) assessing the patient's capacity to make decisions about goals of care for the patient;
- (d) discussing care of the patient with the patient, or a person (the surrogate) who can make decisions on the patient's behalf about care for the patient, and as appropriate with any of the following:
 - (i) members of the patient's family;
 - (ii) other persons who provide care for the patient;
 - (iii) other health practitioners;
- (e) offering in that discussion reasonable options for care of the patient, including alternatives to intensive or escalated care;
- (f) agreeing with the patient or the surrogate on goals of care for the patient that address all major issues identified;
- (g) recording the agreed goals so that:
 - (i) the record can be readily retrieved by other providers of health care for the patient; and
 - (ii) interventions that should, or should not, be made in care of the patient are identified.

Patients could be assessed for "a life-threatening acute illness or injury" (and suspicion that alternatives to active management may be an appropriate clinical choice) through the use of tools that assist in predicting end-of-life, such as the Supportive and Palliative Care Indicators Tool (SPICTTM).

"offering reasonable options for care" means that the patient must be provided with reasonable alternatives to continued intensive/active treatment or escalation of care, including where the patient has not directly asked for such information (in recognition that patients may not ask if they are not aware of such alternatives).

"recording the agreed goals" should be undertaken using standard forms (where available) appropriate to the facility in which a patient is receiving care.

Patients with existing goals of care plans are eligible if such records cannot be readily retrieved by the medical practitioners; or if their condition has changed to the point the record does not reflect the patient's current medical condition and it is reasonable for new goals of care to be developed.

Providers of goals of care services should be appropriately trained to provide end-of-life care options and goals of care discussions.

Item 13899 should not be claimed where the goals of care are defined only in relation to a sub-set of the patient's major issues.

TN.1.12 Cytotoxic Chemotherapy Administration - (Item 13950)

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.1.14 PUVA or UVB Therapy - (Item 14050)

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

Phototherapy should only be used when:

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

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

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

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

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

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

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

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

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

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

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

Items 14203 and 14206 are not payable for artificial insemination.

TN.1.18 Implantable Drug Delivery System for the Treatment of Severe Chronic Spasticity - (Items 14227 to 14237)

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, 14234 and 14237 should be used in accordance with these restrictions.

TN.1.19 Immunomodulating Agent - (Item 14245)

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

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

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

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

TN.1.21 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are

areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

TN.1.22 Cryopreservation of semen (Item 13260)

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

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

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

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

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

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

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

TN.1.24 Emergency Medicine Therapeutic and Procedural Services (Items 14255 to 14288)

Items 14255, 14256, 14257, 14258, 14259, 14260, 14263, 14264, 14265, 14266, 14270, 14272, 14277, 14278, 14280, 14283, 14285 and 14288 relate to therapeutic and procedural services commonly performed in the emergency medicine setting rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the Australasian College for Emergency Medicine (ACEM).

Mirror emergency medicine therapeutic and procedural items are provided within the structure for medical practitioners who are not emergency physicians to ensure a consistent framework for all emergency services, regardless of provider type.

Group T1, Subgroup 14 items 14255 to 14288 (excluding items 14277 and 14278) must be performed in conjunction with and in addition to an emergency attendance (items 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036) by the practitioner under Group A21.

Items 14277 and 14288 (chemical or physical restraints) may be performed as a standalone service or in conjunction with an emergency attendance service in Group A21.

The following notes are provided to assist emergency physicians and medical practitioners in selecting the appropriate therapeutic or procedural item number for Medicare benefit purposes.

Resuscitation (Items 14255, 14256, 14257, 14258 and 14259)

These items include common procedures and processes involved in a resuscitation, which may include ANY of the following - rapid IV access, administration of fluid, vasopressors (via bolus or infusion), adrenaline nebulisers, use of point-of-care ultrasound in conjunction with focused assessment with sonography for trauma (FAST scan), central line access, arterial puncture and or access, ventilation, nasogastric tube insertion and in-dwelling urinary catheter insertion.

Examples of patients requiring resuscitation include: cardiac/respiratory arrest, generalised seizures, undifferentiated shock, severe sepsis +/- shock, anaphylaxis, STEMI, unstable cardiac dysrhythmias, acute stroke, perforated viscus, aortic dissection / ruptured aortic aneurysm, severe electrolyte/endocrine abnormalities (for example, DKA, hyperkalaemia).

Patients requiring resuscitation routinely require a second doctor to assist with access, airway management or other procedures as required. It is the expectation that, in cases where a second doctor is required to provide the resuscitation service, only one Group A21 emergency medicine attendance item may be billed with either the primary or secondary doctor billing a resuscitation item.

Minor Procedure (Items 14263 and 14265) and Procedures (Items 14264 and 14266)

These items account for minor procedures (14263 and 14265) and procedures (14264 and 14266) provided in conjunction with an attendance item under Group A21 and may be claimed for each minor procedure or procedure performed. Where multiple procedures are performed per patient attendance, the relevant procedure item/s may be billed more than once where clinically relevant for the appropriate treatment of the patient.

"minor procedures" could include simple foreign body removal (eg. corneal, intranasal, otic), superifical wound closure (<7cm, not of the face or neck), drainage of small abscess, incision and drainage abscess / cyst / haematoma (including Bartholin's), pulp space drainage, removal of nail of finger/ thumb/ toe, incision of thrombosed external haemorrhoid, rectal prolapse reduction, bladder aspiration (suprapubic tap), passage of urethral sounds, paraphimosis reduction, sigmoidoscopy, simple wound dressings, burns dressings (<5% BSA)

"procedures" could include removal of foreign body from the ear or subcutaneous tissue (incision / closure), superficial laceration repair of the face / neck (including ear, eyelid, lip, nose) or of >7cm elsewhere on body, management of deep/ contaminated wound requiring debridement under general anaesthetic or field block, femoral nerve block, epistaxis cautery / packing, suprapubic cystotomy / catheter, cardioversion / defibrillation, thoracic cavity aspiration for diagnostic purposes, intercostal drain insertion, PEG tube replacement, laryngoscopy (including fibreoptic), nasendoscopy, priapism decompression, abdominal paracentesis, complex wound dressings, burns dressings (>5% BSA)

Management of Fractures (Items 14270 and 14272)

Items 14270 and 14272 are for fracture or dislocation diagnosis and management, excluding aftercare and performed in conjunction with an attendance item under Group A21.

All fractures are billed the same EXCEPT for fractures that are managed as soft tissue injuries which are NOT billed (for example, phalangeal tuft fractures, lateral malleolar tip avulsions). More complex fractures (for example, stable spinal fractures and multiple rib fractures) are included as fractures for billing purposes due to the multiple facets required to manage these injuries.

For fracture/dislocations requiring reduction (in addition to cast immobilisation) then a procedure item (14263, 14264, 14265 or 14266) may also be billed.

Where a patient presents with multiple fractures, the relevant fracture item/s may be billed more than once per attendance where clinically relevant for the appropriate treatment of the patient.

Chemical or Physical Restraints (Items 14277 and 14278)

Items 14277 and 14278 are for the application of chemical or physical restraints, where an acute severe behavioural disturbance necessitates involuntary management with a team-based approach and chemical and / or physical restraints (limited) and / or one on one nursing care to ensure the safety of the patient. Chemical or physical restraints may be performed as a standalone service or in conjunction with an emergency attendance item under Group A21.

Anaesthesia (Items 14280 and 14283) and Emergent Intubation (Items 14285 and 14288)

The anaesthesia items (14280 and 14283) account for all services that would otherwise be billed under the anaesthetic items in the MBS, including the pre anaesthetic consultation, the associated procedure, and any loadings / add-ons (such as duration of anaesthesia or the ASA classification of the patient). Anaesthesia items assume an average of 20 minutes anaesthesia, and an average ASA 3 classification, in an emergent and / or after-hours context.

Emergent intubation items (14285 and 14288) include endotracheal intubation, LMA insertion, front-of-neck access, and insertion of adjunctive airway devices (oro/nasopharyngeal airways).

Patients requiring procedural sedation or emergent intubation/airway management routinely require a second doctor to assist with access, airway management or other procedures as required. It is the expectation that, in cases where a second doctor is required to provide the anaesthesia or intubation service, only one Group A21 emergency medicine attendance item may be billed with either the primary or secondary doctor billing the procedural item.

Items under Subgroup 14 with the 'Anaesthesia' notation allow for Medicare benefits to be paid for a second medical practitioner to provide the anaesthesia service. Where the anaesthesia service is provided by an emergency physician or medical practitioner, anaesthesia items 14280 and 14283 would be claimed. Specialist anaesthetists may not claim items 14280 and 14283 but would provide the service under a relative value guide episode in T7 or T10 of the GMST.

TN.1.25 Extracorporeal photopheresis for treatment of cutaneous T-cell lymphoma

A response, for the purposes of administering MBS item 14249, is defined as attaining a reduction of at least 50% in the overall skin lesion score from baseline, for at least 4 consecutive weeks. Refer to the Product Information for methoxsalen for directions on calculating an overall skin lesion score. The definition of a clinically significant reduction in the Product Information differs to the 50% requirement for MBS-subsidy. Response only needs to be demonstrated after the first six months of treatment.

TN.1.26 In vitro processing with cryopreservation of bone marrow or peripheral blood

MBS rebates for autologous stem cell transplantation are only available for patients with aggressive malignancy or one which has proven refractory to prior treatment, who meet the criteria for treatment according to:

Indications for Autologous and Allogeneic Hematopoietic Cell Transplantation: Guidelines from the American Society for Blood and Marrow Transplantation (2015)

European Society for Blood and Marrow Transplantation: Indications for allo- and auto-SCT for haematological diseases, solid tumours and immune disorders. Current practice in Europe (2015).

In addition, the treatment must be authorised and overseen by a multidisciplinary cancer team

TN.1.27 Appropriate billing of item 13950 – parenteral administration of antineoplastic agents Intent

The intent for item 13950 is to provide services through Medicare for private patients undergoing antineoplastic therapy. Specifically, Medicare benefits will be paid under item 13950 where the patient is administered with an antineoplastic agent or agents via parenteral route, by or on behalf of a specialist or consultant physician, for antineoplastic treatment (including; cytotoxic chemotherapy and monoclonal antibody therapy).

Item 13950 is not intended for treatment via the administration of agents used in anti-resorptive bone therapy or hormonal therapy.

For the purpose of claiming benefits under MBS item 13950, administration of antineoplastic agent/s commences with the establishment of the parenteral route, and ends with the disconnection of the infusion, regardless of the time expired between the commencement and end.

Irrespective of the number of antineoplastic agents administered, medical practitioners can only bill item 13950 once each time the patient presents for treatment, but may be billed on successive treatment days.

Further information relating to antineoplastic therapy services listed on the MBS can be directed to the Department of Health's AskMBS e-mail service at askmbs@health.gov.au. AskMBS responds to enquiries from providers who seek advice on interpretation of MBS items, explanatory notes and associated legislation. The advice is intended to assist health professionals, practice managers and others to understand and comply with MBS billing requirements. AskMBS works closely with policy areas within the Department of Health, and with Services Australia, to ensure enquirers receive accurate, authoritative and up-to-date information.

Administration

Parenteral administration refers to the delivery of a therapeutic agent via injection, as opposed to administration via the alimentary tract or topically (e.g. application of creams or ointments).

Examples of suitable parenteral routes for the administration of cytotoxic chemotherapy and/or monoclonal antibody therapy include:

intravascular; intramuscular; subcutaneous; intrathecal; and intracavitary.

Multiple instances of administration in a single day

Item 13950 covers the administration of one or more antineoplastic agents, and whilst it is not expected that there would be multiple claims for item 13950 on the one day, there are clinical instances where this might occur. In these circumstances, the medical practitioner will need to assure themselves that these instances represent separate and distinctly relevant services and annotate the patients account or Medicare claim form that the services were 'separate occasion', 'separate attendance' or 'separate times' for multiple services provided on the same day'.

Irrespective of the number of antineoplastic agents administered, medical practitioners can only bill item 13950 once each time the patient presents for treatment.

Professional Attendances

An appropriate professional attendance item (such as item 116 for example) may be co-claimed with item 13950, so long as the provisions of the professional attendance are met. For example, in situations where the patient requires ongoing medical practitioner oversight, as a result of ongoing clinical consequences or side effects of the antineoplastic therapy, then the billing of a professional attendance item would be considered appropriate.

Item 13950 should not be claimed in circumstances where the physical act of parenteral administration of antineoplastic agents does not take place. For example, where a patient is admitted to hospital for a period of several days, the oversight of the patient, post administration of an antineoplastic agent/s, is more appropriately covered under a professional attendance item (so long as the provisions of the professional attendance item are met).

By or on behalf of

In modern practice, a nurse typically performs the administration of antineoplastic agent/s, with the medical practitioner maintaining the overall responsibility for the oversight and care of the patient.

The descriptor for item 13950 does not preclude remote or off-site administration of antineoplastic therapy. It is considered appropriate to bill item 13950 where the administration of the antineoplastic agent or agents occurs at a location other than where the consultant physician or specialist is attending, so long as the claiming consultant physician or specialist is satisfied that the administration of the antineoplastic therapy is being performed with the

level of supervision which is generally accepted by the profession as necessary for the appropriate treatment of the patient.

The specialist or consultant physician, who is undertaking or supervising the procedure, will bill the service using the provider number associated with the service location.

For item 13950, a service is taken to be rendered on behalf of a medical practitioner if, and only if, it is rendered by another person who is not a medical practitioner, and who provides the service in accordance with accepted medical practice, and under the supervision of the medical practitioner.

Accessing long-term implanted delivery devices

Accessing a long-term implanted device, such as a peripherally inserted central catheter (PICC) line, for the purpose of administering an antineoplastic agent at the time of administering the antineoplastic agent, is considered an integral component of this service, and therefore should not receive a separate MBS benefit. Item 14221 cannot be claimed in these circumstances.

Providers should note that the fee for item 13950 includes a component for accessing a long-term implanted drug delivery device when administering antineoplastic agents, and should be mindful of this when billing patients for services not specifically listed on the MBS. Note that billing against item 14221, for any reason (e.g. flushing or taking of bloods), is not permitted when the device is accessed for the purpose of delivering the service associated with item 13950.

However, it is recognised that the clinical need for access to an implanted device exists beyond the administration of antineoplastic therapy, for example, flushing a long-term intravascular access device in order to maintain patency during prolonged periods of disuse or giving antibiotic therapy or transfusing blood products or taking a blood sample. Billing against item 14221, in these situations, is considered clinically relevant and appropriate, so long as these services are not associated with the visit by the patient for a course of antineoplastic therapy under item 13950.

Where item 14221 is claimed on the same day as item 13950 for a separate and distinct clinically relevant service, the account for item 14221 must be annotated with 'separate attendance' or 'separate service' to enable the claim to be appropriately assessed. It would be expected that the account would be annotated with time of the attendances to demonstrate that separate services were provided to the patient.

Pumps and other devices

The loading of pumps, reservoirs or ambulatory drug delivery devices can be billed under item 13950 (so long as the conditions described in the item descriptor are met). For the purpose of claiming benefits under MBS item 13950, administration of antineoplastic agent/s commences with the establishment of the parenteral route, and ends with the disconnection of the infusion, regardless of the time expired between the commencement and end.

Irrespective of the number of antineoplastic agents administered, medical practitioners can only bill item 13950 once each time the patient presents for treatment.

Under the MBS, there is no item that specifically covers the disconnection of a pump or device as part of or following the administration of antineoplastic agents.

Item 14221 was amended on 1 November 2020 to clarify that it cannot be claimed in association with the administration of antineoplastic agents for which item 13950 is being claimed, as the MBS fee for item 13950 contains a component to cover accessing of a long-term implanted device for delivery of therapeutic agents.

Item 13950 cannot be claimed where the patient is receiving the infusion at home via a pre-loaded pump or ambulatory delivery device.

If, at the attendance to disconnect a pump or device, the practitioner further administers antineoplastic agents under a service described by item 13950, then item 13950 may be claimed for that episode of treatment. The administration of antineoplastic agents during the attendance to disconnect the pump or device is considered a

separate attendance from the claim associated with the initial loading of the pump or device. Item 14221 cannot be claimed in these circumstances, as item 14221 cannot be claimed in association with a claim for item 13950.

Alternatively, if at the attendance to disconnect a pump or device there is no service provided under item 13950 (i.e. no further administration of antineoplastic agents), then item 14221 may be claimed for a service associated with the accessing of a long-term implanted device for delivery of therapeutic agents, but only under circumstances where the long-term implanted device is accessed for the purpose of delivery of therapeutic agents (e.g. line maintenance for future access). Item 14221 should not be claimed merely for the disconnection of the device.

Therapies

The parenteral administration of antineoplastic agents, including cytotoxic chemotherapy and monoclonal antibody therapy, can be claimed under item 13950.

Item 13950 cannot be used for claims related to the administration of pharmaceuticals used as part of hormonal therapy nor for the administration of colony-stimulating factors. Also, the administration of anti-resorptive bone therapy is not covered under item 13950.

The administration of pharmaceuticals given as part of a treatment regimen for a non-malignant disease cannot be claimed under item 13950. For example, item 13950 cannot be used for claims related to the treatment of multiple sclerosis or for the treatment of arthritis.

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 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. Benefits are also payable for more than one plan when a plan for brachytherapy and a plan for megavoltage or teletherapy treatment are 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.

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

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

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

In these items, 'treatment verification' means:

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

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

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

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

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

Items 15700, 15705, 15710 and 15715:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 16400 can only be claimed 10 times per pregnancy.

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

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

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

TN.4.3 Antenatal Care - (Item 16500)

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

- (a) Items 16501, 16502, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514, 16533, 16534 and 16600 to 16627.
- (b) The initial consultation at which pregnancy is diagnosed.

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

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

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

Contraindications for this item are as follows:

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

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

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

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

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

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

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

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

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

TN.4.6 Caesarean Section - (Item 16520)

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

TN.4.7 Complicated Confinement - (Item 16522)

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

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

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

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

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

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

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

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

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

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

- (i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;
- (ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);
- (iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals

following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over <u>while in labour</u> from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the birth;

- (iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;
- (v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

Normal postnatal care by a medical practitioner would include:-

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

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

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

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

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

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

TN.4.12 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

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

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

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

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

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

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

TN.4.15 COVID-19 Obstetric MBS Telehealth and Telephone attendance items COVID-19 MBS telehealth and phone attendance items by obstetricians, general practitioners, midwives,

nurse and Aboriginal and Torres Strait Islander health practitioners (ceases on 30 September 2020 unless revoked earlier).

The intent of these temporary items is to allow practitioners to provide certain MBS attendances remotely (by videoconference or telephone), in response to COVID-19 pandemic. This can only be done where it is safe, in accordance with relevant professional standards and clinically appropriate to do so.

COVID-19 MBS telehealth services by videoconference is the preferred approach for substituting a face-to-face consultation. However, providers will also be able to offer audio-only services via telephone if video is not available, for which there are separate items.

COVID-19 – TEMPORARY MBS TELEHEALTH ITEMS

OBSTETRICIANS, GPs, MIDWIVES, NURSES OR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PRACTITIONERS ATTENDANCES (from 13 March 2020)

As of 20 April 2020 bulk billing of specialist services is at the discretion of the provider, so long as informed financial consent is obtained prior to the provision of the service.

Service	Existing Items face to face	Telehealth Items - video conference	Telephone items - for when video conferencing is not available
Antenatal Service provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the	16400	91850	91855

supervision of, a medical practitioner			
Postnatal attendance by an obstetrician or GP	16407	91851	91856
Postnatal attendance 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	16408	91852	91857
Antenatal attendance	16500	91853	91858

Further information related to services rendered by an obstetrician/general practitioner/midwife/nurse or Aboriginal and Torres Strait Islander health practitioner can be found in the <u>Temporary Telehealth Bulk-Billed Items for</u> COVID-19 fact sheets.

All MBS items for referred attendances require a valid referral. However, if the obstetrician has previously seen the patient under a referral that is still valid, there is no need to obtain a specific referral for the purposes of claiming the COVID-19 items.

Restrictions

- Phone attendance items only apply if either the practitioner or the patient do not have the capacity to undertake the attendance by telehealth (videoconference).
- The new remote attendance items are to be billed **instead** of the usual face to face MBS items.
- Services do not apply to admitted patients.

Billing Requirements

As of 20 April 2020 bulk billing of specialist services is at the discretion of the provider, so long as informed financial consent is obtained prior to the provision of the service.

Further information on the assignment of benefit for bulk billed temporary COVID-19 MBS telehealth services can be found in the 'Provider Frequently Asked Questions' at MBSonline.gov.au.

Relevant definitions and requirements

For the purposes of these items, **admitted patient** means a patient who is receiving a service that is provided:

- a. as part of an episode of hospital treatment; or
- b. as part of an episode of hospital substitute treatment in respect of which the person to whom the treatment is provided chooses to receive a benefit from a private health insurer.

Note: "hospital treatment" and "hospital-substitute treatment" have the meaning given by subsection 3(1) of the *Health Insurance Act 1973*.

Mental Health Assessments for Obstetric Patients (Items 91851 and 91856)

The COVID-19 items for a postnatal attendance between 4 and 8 weeks after birth (91851 and 91856) include a mental health assessment of the patient, including screening for drug and alcohol use and domestic violence. 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 91851 and 91856 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.

It is expected that the results of the mental health assessment be recorded in the patient's medical record. A record of a patient's decision not to undergo a mental health assessment should also be recorded in the patient's clinical notes

Technical Requirements

The services can be provided by telehealth, or in circumstances when video conferencing is unavailable, by phone.

Telehealth attendance means a professional attendance by video conference where the health practitioner:

- a. has the capacity to provide the full service through this means safely and in accordance with relevant professional standards; and
- b. is satisfied that it is clinically appropriate to provide the service to the patient; and
- c. maintains a visual and audio link with the patient; and
- d. is satisfied that the software and hardware used to deliver the service meets the applicable laws for security and privacy.

Note —only the time where both a visual and audio link is maintained between the patient and the provider can be counted in meeting the relevant item descriptor for telehealth items.

No specific equipment is required to provide Medicare-compliant telehealth services. Practitioners must ensure that their chosen telecommunications solution meets their clinical requirements and satisfies privacy laws. Information on how to select a web conferencing solution is available on the Australian Cyber Security Centre website.

Phone attendance means a professional attendance by telephone where the health practitioner:

- a. has the capacity to provide the full service through this means safely and in accordance with professional standards; and
- b. is satisfied that it is clinically appropriate to provide the service to the patient; and
- c. maintains an audio link with the patient.

Note: A telephone attendance can only be performed in instances where the attendance could not be performed by telehealth (i.e. videoconference).

There are no geographic restrictions on telehealth and telephone services using items 91851, 91852, 91853, 91856, 91857, 91858. In addition, the patient and the practitioner are not required to be a minimum distance apart by road (usually 15 kilometres) when the service is provided.

Where there are restrictions on the number of services for the face to face items that are mirrored, these restrictions will also apply to the new COVID-19 items.

Recording Clinical Notes

In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added later, such as reports of investigations.

Clinicians should retain for their records the date, time and duration of the consultation.

Creating and Updating a My Health Record

The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

- Reviewing a patient's clinical history, in the patient's file and/or the My Health Record, and preparing or updating a Shared Health Summary where it involves the exercise of clinical judgement about what aspects of the clinical history are relevant to inform ongoing management of the patient's care by other providers; or
- Preparing an Event Summary for the episode of care.

Preparing or updating a Shared Health Summary and preparing an Event Summary are clinically relevant activities. When either of these activities are undertaken with any form of patient history taking and/or the other clinically relevant activities that can form part of a consultation, the item that can be billed is the one with the time period that matches the total consultation time.

MBS rebates are not available for creating or updating a Shared Health Summary as a standalone service.

Antenatal Care - (Items 91853 and 91858)

In addition to routine antenatal attendances covered by items 91853 and 91858, 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.

Antenatal Service Provided by a Nurse, Midwife or an Aboriginal and Torres Strait Islander health practitioner - (Items 91850 and 91855)

Items 91850 and 91855 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.

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

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 a practice operated by a medical practitioner.

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 consult with 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 items 91850 and 91855 cannot be claimed in these circumstances.

Items 91850 and 91855 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 items 91850 and 91855. An incentive payment is incorporated into the schedule fee.

Items 91850 and 91855 can only be claimed 10 times per pregnancy in total, including services claimed under item 16400.

None of the items, including 91850 and 91855, can be claimed for an admitted patient of a hospital.

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:

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

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

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

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

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

· vascular access procedures (other than intra-operative peripheral vascular access procedures)

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

NOTE:

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

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

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

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

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

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

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

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

TN.6.4 Telehealth Specialist Services

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

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

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

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

Clinical indications

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

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

Restrictions

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

Billing Requirements

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

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

Eligible Geographical Areas

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

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

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

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

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

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

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

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

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

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

TN.7.1 Regional or Field Nerve Blocks - General

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

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

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

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

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

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

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

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

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

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

This items covers caudal infusion/injection.

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

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

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

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

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

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

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

TN.8.1 Surgical Operations

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

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

An explanation of each of these phrases is as follows.

As an Independent Procedure

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

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

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

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

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

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

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

TN.8.2 Multiple Operation Rule

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

- 100% for the item with the greatest Schedule fee

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

plus 25% for each other item.

Note:

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

- (b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
- (c) The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.
- (d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

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

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

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

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

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

Extended Medicare Safety Net Cap

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

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

TN.8.3 Procedure Performed with Local Infiltration or Digital Block

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

TN.8.4 Aftercare (Post-operative Treatment) Definition

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

Aftercare is deemed to include all post-operative treatment rendered by medical specialists and consultant physicians, and includes all attendances until recovery from the operation, the final check or examination, regardless

of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

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

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

Private Patients

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

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

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

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

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

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

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

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

Public Patients

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

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

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

Fractures

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

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

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

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

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

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

TN.8.5 Abandoned surgery - (Item 30001)

Item 30001 applies 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 and 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 or plastic surgery.

Services Australia (SA) has developed a <u>Health Practitioner Guideline to substantiate proof of malignancy where required for MBS items</u> which is located on the SA 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:

- 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 - 30694, 38416 - 38417)

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 30694, 38416 and 38417.

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 Breast Biopsy Items – items 31533 (Fine Needle Aspiration) and 31548 (Mechanical Device Biopsy)

Breast abnormalities requiring biopsy should be assessed by core biopsy or vacuum-assisted core biopsy. If a service has access to high-quality cytology with immediate reporting, then fine needle aspiration (FNA) may be used in addition to mechanical device biopsy, but not instead of it. In exceptional cases, based on a clinician's judgement, FNA may be used alone if mechanical device biopsy is not possible.

In relation to item 31533 (FNA) an impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

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

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

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

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

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

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

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

Items 31569 to 31581 and item 20791 provide for surgical treatment of clinically severe obesity and the accompanying anaesthesia service (or similar). The term clinically severe obesity generally refers to a patient with a Body Mass Index (BMI) of 40kg/m^2 or more, or a patient with a BMI of 35kg/m^2 or more with other major medical co-morbidities (such as diabetes, cardiovascular disease, cancer). The BMI values in different population groups may vary due, in part, to different body proportions which affect the percentage of body fat and body fat distribution. Consequently, different ethnic groups may experience major health risks at a BMI that is below the 35- 40 kg/m^2 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 33551and 34815)

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

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

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

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

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

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

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

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

TN.8.40 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.8.50 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 Fiducial Markers into the Prostate - (Item 37217)

Item 37217 is for the insertion of 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 (Grade Group 1-3). 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; Grade Group 3), 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 39638 to 39656)

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 39638 to 39656 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[®]) 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 TN.8.126 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 of the patient in the supine position need to demonstrate unacceptable deformity in the form of a discreet concavity to justify use of 45553 or 45554.

In the context of eligibility for item 45553 and 45554, an unacceptable deformity would not include asymmetry caused as a result of removal of one implant out of a pair of implants.

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 the administration of anaesthetic by an anaesthetist for the procedure. Advice from the Royal Australian and New Zealand College of Ophthalmologists is that independent injections require only topical anaesthesia, with or without subconjunctival anaesthesia, except in specific circumstances as outlined below where additional anaesthetic services may be indicated:

- nystagmus or eye movement disorder;
- cognitive impairment precluding safe intravitreal injection without sedation;
- a patient under the age of 18 years;
- a patient unable to tolerate intravitreal injection under local anaesthetic without sedation; or
- endophthalmitis or other inflammation requiring more extensive anaesthesia (eg peribulbar).

Practitioners billing item 42739 must keep clinical notes outlining the basis for the use of anaesthetic.

Item 42740 provides for intravitreal injection of therapeutic substances and/or the removal of vitreous for diagnostic purposes when performed in conjunction with other intraocular surgery including with a service to which Item 42809 (retinal photocoagulation) applies.

TN.8.122 Bone Graft (Items 48200-48242 and 48642-48651)

Bone graft substitute materials can be used for the purpose of bone graft for items 48200-48242 and 48642-48651.

TN.8.123 Vulvoplasty and Labioplasty - (Items 35533 and 35534)

Item 35533 is intended to cover the surgical repair of female genital mutilation or a major congenital anomaly of the uro-gynaecological tract which is not covered by existing MBS items. For example, this item would apply where a patient who has previously received treatment for cloacal extrophy, bladder exstrophy or congenital adrenal hyperplasia requires additional or follow-up treatment.

Item 35534 is intended to cover services for a structural abnormality causing significant functional impairment and is restricted to patients aged 18 years and over.

A detailed clinical history outlining the structural abnormality and the medical need for surgery of the vulva and/or labia must be included in patient notes, as this may be subject to audit.

Medicare benefits are not payable for non-therapeutic cosmetic services.

TN.8.124 Treatment of Wrist and Finger Fractures - (Items 47301 to 47319, and 47361 to 47373)

- For the purposes of these items, fixation includes internal and external.
- Regarding item 47362, major regional anaesthesia includes bier block.

TN.8.125 Removal of Skin Lesions - Necessary Excision Diameter - (Items 31356 to 31376)

The necessary excision diameter (or defect size) refers to the lesion size plus a clinically appropriate margin of healthy tissue required with the intent of complete surgical excision. Measurements should be taken prior to excision. Margin size should be determined in line with NHMRC guidelines:

Clinical practice guide - Basal cell carcinoma, squamous cell carcinoma(and related lesions)-a guide to clinical management in Australia. November 2008. Cancer Council Australia and; Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand (2008).

For the purpose of Items 31356 to 31376 the defect size is calculated by the average of the width and the length of the skin lesion and an appropriate margin. The necessary excision diameter is calculated as shown in the Factsheet at this link: Determining lesion size for MBS item selection.

Practitioners must retain copies of histological reports and any other supporting evidence (patient notes, photographs etc). Photographs should include scale.

An episode of care includes both the excision and closure for the same defect, even when excision and closure occur at separate attendances.

Definitive surgical excision for items 31371 to 31376 means surgical removal with adequate margins as part of the curative management of the malignancies specified in these items.

An incomplete surgical excision of a malignant skin lesion with curative intent should be billed as a malignant skin lesion excision item even when further surgery is needed. Wide excision of the primary tumour bed following local excision of a primary melanoma, appendageal carcinoma, malignant connective tissue or merkel cell carcinoma of the skin may be claimed using item 31371, 31372, 31373, 31374, 31375 or 31376, depending on the location of the malignancy and the size of the excision diameter.

For Items 31356 to 31370, a malignant skin lesion is defined as a basal cell carcinoma; a squamous cell carcinoma (including keratoacanthoma); a cutaneous deposit of lymphoma; or a cutaneous metastasis from an internal malignancy.

TN.8.126 Flap Repair - (Item 45202)

Practitioners must only perform a muscle or skin flap repair where clinical need can be clearly evidenced (i.e. where a patient hassevere pre-existing scarring, severe skin atrophy, sclerodermoid changes or where the defect is contiguous witha free margin).

Clinical evidence may be supported by patient notes, photographs of the affected area and pathology reports.

TN.8.127 Interpretation of femoroacetabular impingement (FAI) restriction (items 48424, 49303,49366)

Patients presenting with hip dysplasia, Perthes Disease and Slipped Upper Femoral Epiphysis (SUFE) are eligible for treatment under items 49366, 49303 and 48424.

TN.8.132 Transcatheter occlusion of left atrial appendage for stroke prevention (item 38276) Explanatory Note

A contraindication to lifelong anticoagulation is defined as:

- i) a previous major bleeding complication experienced whilst undergoing treatment with oral anticoagulation therapy,
- ii) a blood dyscrasia, or
- iii) a vascular abnormality predisposing to potentially life threatening haemorrhage

The procedure is performed as a hospital service.

TN.8.133 Endoscopic upper gastrointestinal strictures (item 30475)

Endoscopic upper GI stricture services 41819 and 41820 have been consolidated under item 30475. This consolidated item will allow any endoscopic technique to be performed for oesophageal through to gastroduodenal procedures and will include imaging intensification if done. The fee is the same as item 41819 which higher than item 30475 but lower than 41820.

TN.8.134 Application of items 32084 and 32087

If a service to which item 32084 or 32087 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 Cancer Council Australia website.

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.8.153 Urology Oncology: Intestinal Conduit - (Items 36600 and 36603)

Patients undergoing these procedures should ideally be treated at a facility adequately resourced for stoma therapy support, where High Dependency Units or Intensive Care Units, experienced nursing staff, and stomal therapy is available.

TN.8.154 Urology Oncology: Nephrectomy and Nephroureterectomy - (Items 36516, 36519, 36522, 36528, 36529, 36531, 36532, 36533 and 36576)

Best practice in treating kidney cancer patients with an estimated glomerular filtration rate (eGFR) <60ml/min/1.73m² involves multi-disciplinary management in collaboration with a nephrologist.

TN.8.155 Paediatric and reconstructive urology: Pyeloplasty - (Item 36567)

Where laparoscopic surgery is used, this should allow for retroperitoneal as well as abdominal approaches.

TN.8.156 Paediatric and reconstructive urology: Ureterolysis - (Item 36615)

Item 36615 should be used only where there is radiological evidence of obstruction or proximal dilatation of the ureter at surgery. Routine dissection of ureter as part of another operation is not considered ureterolysis for ureteric obstruction.

TN.8.157 Urology Oncology: Bladder Excision or Transection - (Items 37000 and 37014)

Best practice in management of invasive bladder cancer is to discuss cases at multi-disciplinary meetings to determine the role of neo-adjuvant chemotherapy prior to surgery or radiation therapy with or without chemotherapy. Information and management decisions on patient care from the multi-disciplinary meeting should be communicated to the referring GP in a timely manner.

TN.8.158 Urology Oncology: Cystoscopy - (Item 36842)

The co-claiming restrictions for 36842 with items 36812, 36827 to 36863, 37203 and 37206, prevent the restricted items from being co-claimed as part of the same procedure, but do not prevent the restricted items from being claimed as separate procedures on the same day.

TN.8.159 General Urology: Bladder repair and Cystotomy - (Item 37011)

Co-claiming of this item is reasonable in urgent situations that cannot be resolved with a urethral catheter alone.

TN.8.160 Urology Oncology: Prostate Biopsy - (Item 37216 and 37219)

Best practice is to ensure patients are informed of the uncommon but serious risk of severe infection when a transrectal needle biopsy is performed, and that alternative methods of biopsy are available that reduces this risk. Practitioners are to ensure that the referring GP is informed of the biopsy result as soon as possible (optimally 2-4 weeks) after the biopsy. This ensures that GPs will be informed early after diagnosis of prostate cancer, and will be in a better position to support the patient after diagnosis.

TN.8.161 Urology Oncology: Prostatectomy - (Items 37210, 37211, 37213 and 37214)

Best practice prior to claiming for a 37210, 37211, 37213 and 37214 would be for the operating surgeon to have a long consult with the patient within 6 months prior to surgery to discuss and provide patients with written information about all guideline-endorsed treatment options for their condition. A thorough consult discussing all available treatment modalities, is required to ensure patients make well-informed decision about their treatment.

Multi-disciplinary management constitutes clinical best practice in patients with intermediate risk or advanced prostate cancer. As such, patients should ideally be reviewed by a multi-disciplinary team before a treatment decision is made. Multi-disciplinary teams involve radiation oncologists (for alternate radical treatments), medical oncologists (for adjuvant or therapeutic approaches) and other disciplines (e.g. urology nurses, exercise physiotherapists, exercise physiotherapists, physiotherapists, psychologists, pathologists, radiologists). Recommendations from multi-disciplinary reviews should be documented in writing and provided to the patient and referring GP.

Men in whom curative treatment for prostate cancer is recommended, should be offered and encouraged to discuss treatment options with a urologist and a radiation oncologist prior to any treatment, as part of fully informed decision making. A record of a patient's decision not to accept a referral to a radiation oncologist (from the urologist or general practitioner) should be clearly documented in the patient's medical record.

TN.8.162 Prostate: Benign prostatic hyperplasia and prostatectomy - (Item 37200)

The laparoscopic or robotic assisted approaches to prostatectomy may include trans-peritoneal or extra-peritoneal access.

TN.8.163 Prostate: Benign prostatic hyperplasia by ablation - (Items 37230 and 37233)

Items 37230 and 37233 should be used to treat benign prostate hyperplasia.

TN.8.164 General Urology: Lengthening of penis - (Item 37423)

The partial penectomy or penile epispadias secondary repair does not need to occur during the same episode that item 37423 is claimed.

TN.8.165 General Urology: Lymph Node Dissection - (Item 37607 and 37610)

Items 37607 and 37610 should be performed using a bilateral template.

TN.8.166 Item 40803 - co-claiming restrictions

Items 39015, 39503, 39906 and 40104 do not apply to a service if the service is provided in conjunction with the service described in item 40803.

TN.9.1 Assistance at Operations - (Items 51300 to 51318)

Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

NOTE: The Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

Assistance at Multiple Operations

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

Multiple Operation Rule - Surgeon	Multiple Operation Rule - Assistant
Item A - \$300@100%	Item A (Assist.) - \$300@100%
Item B - \$250@50%	Item B (No Assist.)
Item C - \$200@25%	Item C (Assist.) - \$200@50%
Item D - \$150@25%	Item D (Assist.) - \$150@25%

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

Surgeons Operating Independently

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

TN.9.2 Benefits Payable under Item 51300

Medicare benefits are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

TN.9.3 Benefits Payable Under Item 51303

Medicare benefits are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

TN.9.4 Benefits Payable Under Item 51309

Medicare benefits are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a birth involving Caesarean section.

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

TN.9.5 Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

TN.10.1 Relative Value Guide For Anaesthetics - (Group T10) Overview of the RVG

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

Details of the billing requirements for the RVG are available from the Department of Human Services website.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the MBS fee for anaesthesia in connection with a procedure is comprised of up to three components:

- 1. The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997);
- 2. The time unit allocation reflecting the total time of the anaesthesia (an item in the range 23010-24136); and
- 3. Where appropriate, modifying units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020).

Assistance at anaesthesia

To establish the fee for the assistant service items 25200 and 25205, both services have been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers as appropriate to determine the MBS fee.

Whole body perfusion

Where whole body perfusion is performed, the MBS fee is determined by adding together the following:

- 1. The base units allocated to the service (item 22060);
- 2. The time unit allocation reflecting the total time of the perfusion (an item in the range 23010 24136); and
- 3. Where appropriate, modifying units recognising certain added complexities in perfusion (an item/s in the range 25000 25020).

TN.10.2 Eligible Services

Generally, a Medicare benefit is only payable for anaesthesia which is performed in connection with an "eligible" service. An "eligible" service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee.

TN.10.3 RVG Unit Values

Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- *for anaesthesia*, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- for assistance at anaesthesia, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- for perfusion, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

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 under 4 years old or at least 75 years (item 25013 or 25014).
- 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.

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	24	\$482.40
25000	Modifier - Physical sttaus	1	\$20.10
22012	Central Venous Pressure Monitoring	3	\$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

^{*} 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 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	. n	(lower value than 20790 = 20752 schedule fee not payable) \$120.60
23111	Time - 2hrs 30mins	11	\$221.10
25014	Physical Status - 75 or over	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 complementary 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 <u>other</u> than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

Items 22012 and 22014

Benefits are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

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 25013, and/or item 25014, 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 aged 75 years or more (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 osteotomies 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: www.pbs.gov.au/browse/section100-mf

Item 18354 for the treatment of equinus, equinovarus or equinovalgus is limited to a maximum of 4 injections per patient on any day (2 per limb). Accounts should be annotated with the limb which has been treated. Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used, in addition to botulinum toxin injection(s), to treat the obturator nerve in patients with a dynamic foot deformity.

Treatment under item 18375 or 18379 can only continue if the patient achieves at least a 50% reduction in urinary incontinence episodes from baseline from the start of week 6 through to the end of week 12 after the first treatment. The term 'continue' means the patient can be retreated under item 18375 or 18379 at some point after the 12 week period (for example; 6 to 12 months after the first treatment). This requirement is in line with the PBS listing for the supply of the medicine for this indication under Section 100 of the *Act*.

Item 18362 for the treatment of severe primary axillary hyperhidrosis allows for a maximum number of 3 treatments per patient in a 12 month period, with no less than 4 months to elapse between treatments.

Botulinum toxin which is not supplied and administered in accordance with the arrangements under Section 100 of the *Act* is not required to be provided free of charge to patients. Where a charge is made for the botulinum toxin administered, it must be separately listed on the account and not billed to Medicare. Since 1 September 2015, PBS patient co-payments have applied to botulinum toxin supplied and administered in accordance with the arrangements under Section 100 of the Act.

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

TR.8.1 Mechanical thrombectomy - (Item 35414)

For the purposes of this item, *eligible stroke centre* means a facility that:

- (a) has a designated stroke unit;
- (b) is equipped and has staff available or on call so that it is capable of providing the following to a patient on a 24-hour basis:
 - (i) the services of a specialist or consultant physician who has the training required under paragraph (b) of item 35414;
 - (ii) diagnostic imaging services using advanced imaging techniques, which must include computed tomography, computed tomography angiography, digital subtraction angiography, magnetic resonance imaging, and magnetic resonance angiography; and
 - (iii) care from a team of health practitioners which includes a stroke physician, a neurologist, a neurosurgeon, a radiologist, an anaesthetist, an intensive care unit specialist, a medical imaging technologist, and a nurse;
- (c) has dedicated endovascular angiography facilities; and
- (d) has written procedures for assessing and treating patients who have, or may have, experienced a stroke.

Note: A health practitioner may fulfil the role of more than one of the types of health practitioner specified in paragraph (b)(iii). For example, a neurologist may also be a stroke physician.

Conjoint Committee for Recognition of Training in Interventional Neuroradiology (CCINR)

CCINR comprises representatives from the Australian and New Zealand Society of Neuroradiology (ANZSNR), the Neurosurgical Society of Australasia (NSA) and the Australian and New Zealand Association of Neurologists (ANZAN). For the purposes of this item, specialists or consultant physicians performing this procedure must have training recognised by CCINR, and the Department of Human Services notified of that recognition.

THERAPEUTIC PROCEDURES ITEMS

T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 1. HYPERBARIC OXYGEN THERAPY
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 1. Hyperbaric Oxygen Therapy
	HYPERBARIC, OXYGEN THERAPY, for treatment of localised non-neurological soft tissue radiation injuries excluding radiation-induced soft tissue lymphoedema of the arm after treatment for breast cancer, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance.
13015	(See para TN.1.1 of explanatory notes to this Category) Fee: \$262.75 Benefit: 75% = \$197.10 85% = \$223.35
	HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance
13020	(See para TN.1.1 of explanatory notes to this Category) Fee: \$266.95 Benefit: 75% = \$200.25 85% = \$226.95
	HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour)
13025	(See para TN.1.1 of explanatory notes to this Category) Fee: \$119.30 Benefit: 75% = \$89.50 85% = \$101.45
	HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour)
13030	(See para TN.1.1 of explanatory notes to this Category) Fee: \$168.55 Benefit: 75% = \$126.45 85% = \$143.30
T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 2. DIALYSIS
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 2. Dialysis
	SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day
13100	(See para TN.1.2 of explanatory notes to this Category) Fee: \$140.95 Benefit: 75% = \$105.75 85% = \$119.85
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) Fee: \$73.45 Benefit: 75% = \$55.10 85% = \$62.45
	Planning and management of home dialysis (either haemodialysis or peritoneal dialysis), by a consultant physician in the practice of his or her specialty of renal medicine, for a patient with end-stage renal disease, and supervision of that patient on self-administered dialysis, to a maximum of 12 claims per year
13104	(See para TN.1.3, TN.1.23 of explanatory notes to this Category) Fee: \$152.55 Benefit: 85% = \$129.70
	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	Fee: \$610.45 Benefit: 100% = \$610.45
	DECLOTTING OF AN ARTERIOVENOUS SHUNT
13106	Fee: \$125.15 Benefit: 75% = \$93.90 85% = \$106.40
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)
13109	Fee: \$234.85 Benefit: 75% = \$176.15 85% = \$199.65
	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS, removal of (including catheter cuffs) (Anaes.)
13110	Fee: \$235.65 Benefit: 75% = \$176.75 85% = \$200.35
T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	Group T1. Miscellaneous Therapeutic Procedures
	Subgroup 3. Assisted Reproductive Services
13200	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13201, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - INITIAL cycle in a single

PROCE	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
	calendar year
	(See para TN.1.4 of explanatory notes to this Category) Fee: \$3,207.90
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE PROCEEDING TO OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13200, 13202, 13203, 13206, 13218 applies - being services rendered during 1 treatment cycle - each cycle SUBSEQUENT to the first in a single calendar year
13201	(See para TN.1.4 of explanatory notes to this Category) Fee: \$3,000.65 Benefit: 75% = \$2250.50 85% = \$2915.95 Extended Medicare Safety Net Cap: \$2,488.35
	ASSISTED REPRODUCTIVE TECHNOLOGIES SUPEROVULATED TREATMENT CYCLE THAT IS CANCELLED BEFORE OOCYTE RETRIEVAL, involving the use of drugs to induce superovulation and including quantitative estimation of hormones, semen preparation, ultrasound examinations, but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which Item 13200, 13201, 13203, 13206, 13218, applies being services rendered during 1 treatment cycle
13202	(See para TN.1.4 of explanatory notes to this Category) Fee: \$480.10 Benefit: 75% = \$360.10 85% = \$408.10 Extended Medicare Safety Net Cap: \$66.45
	OVULATION MONITORING SERVICES, for artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which Item 13200, 13201, 13202, 13206, 13212, 13215, 13218, applies
13203	(See para TN.1.4 of explanatory notes to this Category) Fee: \$501.95 Benefit: 75% = \$376.50 85% = \$426.70 Extended Medicare Safety Net Cap: \$110.65
	ASSISTED REPRODUCTIVE TECHNOLOGIES TREATMENT CYCLE using either the natural cycle or oral medication only to induce oocyte growth and development, and including quantitative estimation of hormones, semen preparation, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of injectable drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies
13206	(See para TN.1.4 of explanatory notes to this Category) Fee: \$480.10 Benefit: 75% = \$360.10 85% = \$408.10 Extended Medicare Safety Net Cap: \$66.45
	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies or for artificial insemination payable once only during 1 treatment cycle
13209	(See para TN.1.4 of explanatory notes to this Category) Fee: \$87.35 Benefit: 75% = \$65.55 Extended Medicare Safety Net Cap: \$11.15
13210	Professional attendance on a patient by a specialist practising in his or her specialty if:

T1. MIS	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICES
1.1.002	(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: \$5.45
	Oocyte retrieval for the purpose of assisted reproductive technologies-only if rendered in connection with a service to which item 13200, 13201 or 13206 applies (Anaes.)
13212	(See para TN.1.4 of explanatory notes to this Category) Fee: \$365.50 Benefit: 75% = \$274.15 Extended Medicare Safety Net Cap: \$72.00
	Transfer of embryos or both ova and sperm to the uterus or fallopian tubes, excluding artificial insemination-only if rendered in connection with a service to which item 13200, 13201, 13206 or 13218 applies, being services rendered in one treatment cycle (Anaes.)
13215	(See para TN.1.4 of explanatory notes to this Category) Fee: \$114.60 Benefit: 75% = \$85.95 Extended Medicare Safety Net Cap: \$49.85
	PREPARATION of frozen or donated embryos or donated oocytes for transfer to the uterus or fallopian tubes, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13201, 13202, 13203, 13206, 13212 applies (Anaes.)
13218	(See para TN.1.4, TN.1.5 of explanatory notes to this Category) Fee: \$818.35 Benefit: 75% = \$613.80 85% = \$733.65 Extended Medicare Safety Net Cap: \$718.90
	Preparation of semen for the purpose of artificial insemination-only if rendered in connection with a service to which item 13203 applies
13221	(See para TN.1.4 of explanatory notes to this Category) Fee: \$52.35 Benefit: 75% = \$39.30 85% = \$44.50 Extended Medicare Safety Net Cap: \$22.20
13221	Zatenticu recurente Dutety Tite Cup. 422.20

	CELLANEOUS THERAPEUTIC DURES 3. ASSISTED REPRODUCTIVE SERVICE
	INTRACYTOPLASMIC SPERM INJECTION for the purposes of assisted reproductive technologies, for male factor infertility, excluding a service to which Item 13203 or 13218 applies
13251	(See para TN.1.5 of explanatory notes to this Category) Fee: \$431.00 Benefit: 75% = \$323.25 85% = \$366.35 Extended Medicare Safety Net Cap: \$110.65
	Processing and cryopreservation of semen for fertility preservation treatment before or after completion of gonadotoxic treatment for malignant or non-malignant conditions, in a post-pubertal male in Tanner stages II-V, up to 60 years old, if the patient is referred by a specialist or consultant physician, initial cryopreservation of semen (not including storage) - one of a maximum of two semen collection cycles per patient in a lifetime.
13260	(See para TN.1.22 of explanatory notes to this Category) Fee: \$427.95 Benefit: 75% = \$321.00 85% = \$363.80 Extended Medicare Safety Net Cap: \$278.20
	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required
13290	Fee: \$210.60 Benefit: 75% = \$157.95 85% = \$179.05
	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 electric singulation devices including aethors is an address of bladden where required and are
	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: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 CELLANEOUS THERAPEUTIC
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA
T1. MIS	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 CELLANEOUS THERAPEUTIC DURES 4. PAEDIATRIC & NEONATA Group T1. Miscellaneous Therapeutic Procedures Subgroup 4. Paediatric & Neonatal UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 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: \$58.70 Benefit: 75% = \$44.05 85% = \$49.90
T1. MIS PROCE	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 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: \$58.70 Benefit: 75% = \$44.05 85% = \$49.90 UMBILICAL ARTERY CATHETERISATION with or without infusion
13300 13303	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 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: \$58.70 Benefit: 75% = \$44.05 85% = \$49.90 UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$87.05 Benefit: 75% = \$65.30 85% = \$74.00 BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection
13300 13303	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 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: \$58.70 Benefit: 75% = \$44.05 85% = \$49.90 UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$87.05 Benefit: 75% = \$65.30 85% = \$74.00 BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor
	general anaesthetic, in a hospital (Anaes.) Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30 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: \$58.70 Benefit: 75% = \$44.05 85% = \$49.90 UMBILICAL ARTERY CATHETERISATION with or without infusion Fee: \$87.05 Benefit: 75% = \$65.30 85% = \$74.00 BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor Fee: \$344.55 Benefit: 75% = \$258.45 85% = \$292.90 BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already

T1. MIS PROCE	CELLANEOUS T DURES	HERAPEUTIC	4. PAEDIATRIC & NEONATAL
	Fee: \$29.35	Benefit: 75% = \$22.05 85% = \$24.95	
	CENTRAL VEI	N CATHETERISATION - by open exposure in	n a person under 12 years of age (Anaes.)
13318	(See para TN.1.6 or Fee: \$234.55	of explanatory notes to this Category) Benefit: 75% = \$175.95 85% = \$199.40	
	CENTRAL VEI	N CATHETERISATION in a neonate via perip	oheral vein (Anaes.)
13319	Fee: \$234.55	Benefit: 75% = \$175.95 85% = \$199.40	
	CELLANEOUS T DURES	HERAPEUTIC	5. CARDIOVASCULAR
	Group T1. Misc	ellaneous Therapeutic Procedures	
		Subgroup 5. Cardiovaso	cular
		N OF CARDIAC RHYTHM by electrical stimuc surgery (Anaes.)	lation (cardioversion), other than in the
13400	Fee: \$99.85	Benefit: 75% = \$74.90 85% = \$84.90	
_	CELLANEOUS T DURES	HERAPEUTIC	6. GASTROENTEROLOGY
	Group T1. Misc	ellaneous Therapeutic Procedures	
		Subgroup 6. Gastroenter	rology
	GASTRO-OESO	OPHAGEAL balloon intubation, for control of	bleeding from gastric oesophageal varices
13506	Fee: \$190.25	Benefit: 75% = \$142.70 85% = \$161.75	
	CELLANEOUS T DURES	HERAPEUTIC	8. HAEMATOLOGY
	Group T1. Misc	ellaneous Therapeutic Procedures	
		Subgroup 8. Haematol	ogy
		OF HOMOLOGOUS (including allogeneic) or plantation (Anaes.)	AUTOLOGOUS bone marrow for the
13700	Fee: \$343.70	Benefit: 75% = \$257.80 85% = \$292.15	
	Transfusion of b haemodilution	lood, including collection from donor, when us	ed for intra-operative normovolaemic
13703	Fee: \$123.20	Benefit: 75% = \$92.40 85% = \$104.75	
	TRANSFUSION	OF BLOOD or bone marrow already collected	d
13706	(See para TN.1.7 o Fee: \$85.95	of explanatory notes to this Category) Benefit: 75% = \$64.50 85% = \$73.10	
13750	utilising continu	C HAEMAPHERESIS for the removal of plasm ous or intermittent flow techniques; including r if performed; continuous monitoring of vital si	norphological tests for cell counts and

	CELLANEOUS THERAPEUTIC EDURES 8. HAEMATOLOGY
	other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day
	Fee: \$140.95 Benefit: 75% = \$105.75 85% = \$119.85
	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous of intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day
13755	Fee: \$140.95 Benefit: 75% = \$105.75 85% = \$119.85
	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda
13757	Fee: \$75.20 Benefit: 75% = \$56.40 85% = \$63.95
	In vitro processing with cryopreservation of bone marrow or peripheral blood, for autologous stem cell transplantation for a patient receiving high-dose chemotherapy for management of:
	(a) aggressive malignancy; or
	(b) malignancy that has proven refractory to prior treatment
	(See para TN.1.26 of explanatory notes to this Category)
13760	(See para TN.1.26 of explanatory notes to this Category) Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70
T1. MIS	
T1. MIS	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 SCELLANEOUS THERAPEUTIC 9. PROCEDURES ASSOCIATED WITH INTENSIVE
T1. MIS	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 GELLANEOUS THERAPEUTIC EDURES 9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
T1. MIS	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 CELLANEOUS THERAPEUTIC DURES 9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT Group T1. Miscellaneous Therapeutic Procedures
T1. MIS	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 CELLANEOUS THERAPEUTIC DURES 9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT Group T1. Miscellaneous Therapeutic Procedures Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by
T1. MIS	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 GCELLANEOUS THERAPEUTIC EDURES 9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT Group T1. Miscellaneous Therapeutic Procedures Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.)
T1. MIS	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 GCELLANEOUS THERAPEUTIC
T1. MIS PROCE	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 GELLANEOUS THERAPEUTIC CARE AND CARDIOPULMONARY SUPPORT Group T1. Miscellaneous Therapeutic Procedures Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.) No separate ultrasound item is payable with this item. (Anaes.) (See para TN.1.6, TN.1.10 of explanatory notes to this Category) Fee: \$117.20 Benefit: 75% = \$87.90 85% = \$99.65 RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and
T1. MIS PROCE	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT Group T1. Miscellaneous Therapeutic Procedures Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.) No separate ultrasound item is payable with this item. (Anaes.) (See para TN.1.6, TN.1.10 of explanatory notes to this Category) Fee: \$117.20 Benefit: 75% = \$87.90 85% = \$99.65 RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) (See para TN.1.10 of explanatory notes to this Category)
T1. MIS	Fee: \$786.40 Benefit: 75% = \$589.80 85% = \$701.70 9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT Group T1. Miscellaneous Therapeutic Procedures Subgroup 9. Procedures Associated With Intensive Care And Cardiopulmonary Support Central vein catheterisation, including under ultrasound guidance where clinically appropriate, by percutaneous or open exposure other than a service to which item 13318 applies (Anaes.) No separate ultrasound item is payable with this item. (Anaes.) (See para TN.1.6, TN.1.10 of explanatory notes to this Category) Fee: \$117.20 Benefit: 75% = \$87.90 85% = \$99.65 RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) (See para TN.1.10 of explanatory notes to this Category) Fee: \$117.25 Benefit: 75% = \$87.95 85% = \$99.70 INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid

	CELLANEOUS THERAPEUTIC DURES 9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
	No separate ultrasound item is payable with this item	
	(See para TN.1.10 of explanatory notes to this Category) Fee: \$909.30 Benefit: 75% = \$682.00 85% = \$824.60	
	Veno-arterial cardiopulmonary extracorporeal life support, management of—the first day	
13834	(See para TN.1.10 of explanatory notes to this Category) Fee: \$509.05 Benefit: 75% = \$381.80 85% = \$432.70	
	Veno-arterial cardiopulmonary extracorporeal life support, management of—each day after the first	
13835	(See para TN.1.10 of explanatory notes to this Category) Fee: \$118.45 Benefit: 75% = \$88.85 85% = \$100.70	
	Veno-venous pulmonary extracorporeal life support, management of—the first day	
13837	(See para TN.1.10 of explanatory notes to this Category) Fee: \$509.05 Benefit: 75% = \$381.80 85% = \$432.70	
	Veno-venous pulmonary extracorporeal life support, management of—each day after the first	
13838	(See para TN.1.10 of explanatory notes to this Category) Fee: \$118.45 Benefit: 75% = \$88.85 85% = \$100.70	
	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes	
13839	Fee: \$23.75 Benefit: 75% = \$17.85 85% = \$20.20	
	Peripheral cannulation, including under ultrasound guidance where clinically appropriate, for venovenous pulmonary extracorporeal life support No separate ultrasound item is payable with this item	
13840	(See para TN.1.10 of explanatory notes to this Category) Fee: \$609.20 Benefit: 75% = \$456.90 85% = \$524.50	
	Intra-arterial cannulation, including under ultrasound guidance where clinically appropriate, for the purpose of intra-arterial pressure monitoring or arterial blood sampling (or both)	
	No separate ultrasound item is payable with this item	
13842	(See para TN.1.10 of explanatory notes to this Category) Fee: \$96.50 Benefit: 75% = \$72.40 85% = \$82.05	
	Counterpulsation by intra-aortic balloon-management including associated consultations and monitoring of parameters by means of full haemodynamic assessment and management on several occasions on a day – each day	
13848	(See para TN.1.10 of explanatory notes to this Category) Fee: \$161.00 Benefit: 75% = \$120.75 85% = \$136.85	
	Ventricular assist device, management of, for a patient admitted to an intensive care unit for implantation of the device or for complications arising from implantation or management of the device - first day	
13851	(See para TN.1.10 of explanatory notes to this Category) Fee: \$509.05 Benefit: 75% = \$381.80 85% = \$432.70	
13854	Ventricular assist device, management of, for a patient admitted to an intensive care unit, including	

	SCELLANEOUS THERAPEUTIC EDURES	9. PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
	management of complications arising fro the first day	m implantation or management of the device - each day after
	(See para TN.1.10 of explanatory notes to this Fee: \$118.45 Benefit: 75% = \$88.8	
		T OF AND INITIATION OF MECHANICAL VENTILATION ic for surgery), outside an Intensive Care Unit, for the purpose ntensive Care Unit
13857	(See para TN.1.10 of explanatory notes to this Fee: \$151.00 Benefit: 75% = \$113	
	SCELLANEOUS THERAPEUTIC EDURES	10. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNI
	Group T1. Miscellaneous Therapeutic I	Procedures
	Subgroup 10. Management A	And Procedures Undertaken In An Intensive Care Unit
	(Note: See pa	ara T1.8 of Explanatory Notes to this
	Category for	definition of an Intensive Care Unit)
		sive Care Unit by a specialist or consultant physician who is
	immediately available and exclusively ro attendances, electrocardiographic monito management on the first day (H)	stered for intensive care - including initial and subsequent bring, arterial sampling and bladder catheterisation -
13870	immediately available and exclusively ro attendances, electrocardiographic monito	stered for intensive care - including initial and subsequent bring, arterial sampling and bladder catheterisation - matory notes to this Category)
13870	immediately available and exclusively ro attendances, electrocardiographic monitor management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of explant Fee: \$373.40 Benefit: 75% = \$280 MANAGEMENT of a patient in an Intensimmediately available and exclusively ro	stered for intensive care - including initial and subsequent bring, arterial sampling and bladder catheterisation - matory notes to this Category)
	immediately available and exclusively ro attendances, electrocardiographic monito management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of explar Fee: \$373.40 Benefit: 75% = \$280 MANAGEMENT of a patient in an Inten immediately available and exclusively ro electrocardiographic monitoring, arterial	estered for intensive care - including initial and subsequent bring, arterial sampling and bladder catheterisation - matory notes to this Category) 0.05 usive Care Unit by a specialist or consultant physician who is estered for intensive care - including all attendances, sampling and bladder catheterisation - management on each uses to this Category)
13870 13873	immediately available and exclusively ro attendances, electrocardiographic monitor management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanation of a patient in an Intensificately available and exclusively roselectrocardiographic monitoring, arterial day subsequent to the first day (H) (See para TN.1.9, TN.1.11 of explanatory note the second of the second	estered for intensive care - including initial and subsequent oring, arterial sampling and bladder catheterisation - matory notes to this Category) 0.05 usive Care Unit by a specialist or consultant physician who is estered for intensive care - including all attendances, sampling and bladder catheterisation - management on each uses to this Category) 0.75 unonary arterial pressure, systemic arterial pressure or cardiac
	immediately available and exclusively ro attendances, electrocardiographic monito management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanted street should be should	estered for intensive care - including initial and subsequent bring, arterial sampling and bladder catheterisation - matory notes to this Category) 0.05 usive Care Unit by a specialist or consultant physician who is estered for intensive care - including all attendances, sampling and bladder catheterisation - management on each uses to this Category) 0.75 0.75 0.75 0.75 0.75 0.75 0.75 0.75
13873	immediately available and exclusively ro attendances, electrocardiographic monitor management on the first day (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanation of a patient in an Intensificately available and exclusively roselectrocardiographic monitoring, arterial day subsequent to the first day (H) (See para TN.1.9, TN.1.11 of explanatory note fee: \$277.00 Benefit: 75% = \$207 CENTRAL VENOUS PRESSURE, pulmintracavity pressure, continuous monitoriby a specialist or consultant physician whintensive care - once only for each type of pressures) (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanation of the pressures) (H) (See para TN.1.9, TN.1.11, TN.1.10 of explanation of the para TN.1.9, TN.1.11, TN.1.10 of explanation of the parameters of the pressures of the parameters of the paramete	estered for intensive care - including initial and subsequent oring, arterial sampling and bladder catheterisation - matory notes to this Category) 2.05 asive Care Unit by a specialist or consultant physician who is estered for intensive care - including all attendances, sampling and bladder catheterisation - management on each ses to this Category) 2.75 monary arterial pressure, systemic arterial pressure or cardiac and by indwelling catheter in an intensive care unit and management is immediately available and exclusively rostered for of pressure on any calendar day (up to a maximum of 4

T1. MIS	CELLANEOUS THERAPEUTIC 10. MANAGEMENT AND PROCEDURES DURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
	Fee: \$151.00 Benefit: 75% = \$113.25	
	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by invasive means, or by non-invasive means where the only alternative to non-invasive ventilatory support would be invasive ventilatory support, by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care, each day (H)	
13882	(See para TN.1.9, TN.1.11 of explanatory notes to this Category) Fee: \$118.85 Benefit: 75% = \$89.15	
	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on the first day (H)	
13885	(See para TN.1.9, TN.1.11 of explanatory notes to this Category) Fee: \$158.45 Benefit: 75% = \$118.85	
	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, in an intensive care unit, management by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care - on each day subsequent to the first day (H)	
13888	(See para TN.1.9, TN.1.11 of explanatory notes to this Category) Fee: \$79.30 Benefit: 75% = \$59.50	
	Preparation of Goals of Care is provided outside of an intensive care unit. Refer to explanatory note TN.1.11 for further information about Goals of Care attendance Professional attendance, outside an intensive care unit, for at least 60 minutes spent in preparation of goals of care for a gravely ill patient lacking current goals of care, by a specialist in the specialty of	
	intensive care who takes overall responsibility for the preparation of the goals of care for the patient	
	Item 13899 cannot be co-claimed with item 13870 or item 13873 on the same day	
13899	(See para TN.1.11 of explanatory notes to this Category) Fee: \$276.25 Benefit: 75% = \$207.20 85% = \$234.85 Extended Medicare Safety Net Cap: \$500.00	
T1. MIS PROCE	CELLANEOUS THERAPEUTIC DURES 11. CHEMOTHERAPEUTIC PROCEDURES	
	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 11. Chemotherapeutic Procedures	
	Parenteral administration of one or more antineoplastic agents, including agents used in cytotoxic chemotherapy or monoclonal antibody therapy but not agents used in anti-resorptive bone therapy or hormonal therapy, by or on behalf of a specialist or consultant physician—attendance for one or more episodes of administration	
	Note: The fee for item 13950 contains a component which covers the accessing of a long-term drug delivery device. TN.1.27 refers	
13950 S	(See para TN.1.12, TN.1.27 of explanatory notes to this Category) Fee: \$111.40 Benefit: 75% = \$83.55 85% = \$94.70	

	CELLANEOUS THERAPEUTIC DURES 12. DERMATOLOGY	
	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 12. Dermatology	
	UVA or UVB phototherapy administered in a whole body cabinet or hand and foot cabinet including associated consultations other than the initial consultation, if treatment is initiated and supervised by a specialist in the specialty of dermatology	
	Applicable not more than 150 times in a 12 month period	
14050	(See para TN.1.14 of explanatory notes to this Category) Fee: \$54.40 Benefit: 75% = \$40.80 85% = \$46.25	
	Laser photocoagulation using laser radiation in the treatment of vascular abnormalities of the head or neck, including any associated consultation, if:	
	(a) the abnormality is visible from 3 metres; and	
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes;	
	to a maximum of 4 sessions (including any sessions to which this item or any of items 14106 to 14118 apply) in any 12 month period (Anaes.)	
14100	(See para TN.1.15 of explanatory notes to this Category) Fee: \$157.25 Benefit: 75% = \$117.95 85% = \$133.70 Extended Medicare Safety Net Cap: \$125.80	
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), if the abnormality is visible from 3 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12	
	month period—area of treatment less than 150 cm ² (Anaes.)	
14106	(See para TN.1.15 of explanatory notes to this Category) Fee: \$165.15 Benefit: 75% = \$123.90 85% = \$140.40	
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14118 apply) in any 12 month period—area of treatment 150 cm ² to 300 cm ² (Anaes.)	
14115	(See para TN.1.15 of explanatory notes to this Category) Fee: \$264.50 Benefit: 75% = \$198.40 85% = \$224.85	
	Laser photocoagulation using laser radiation in the treatment of vascular malformations, infantile haemangiomas, café au lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which this item or any of items 14100 to 14115 apply) in any 12 month period—area of treatment more than 300 cm ² (Anaes.)	
14118	(See para TN.1.15 of explanatory notes to this Category) Fee: \$335.90 Benefit: 75% = \$251.95 85% = \$285.55	
14124	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),	

	CELLANEOUS THERAPEUTIC EDURES 12. DERMATOLO	٥G١
	including any associated consultation, if:	
	(a) a seventh or subsequent session (including any sessions to which this item or any of items 14100 14118 apply) is indicated in a 12 month period commencing on the day of the first session; and	to
	(b) photographic evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	i
	(See para TN.1.15 of explanatory notes to this Category) Fee: \$157.25 Benefit: 75% = \$117.95 85% = \$133.70	
	CELLANEOUS THERAPEUTIC DURES 13. OTHER THERAPEUTIC PROCEDUI	RES
	Group T1. Miscellaneous Therapeutic Procedures	
	Subgroup 13. Other Therapeutic Procedures	
	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: \$244.25 Benefit: 75% = \$183.20 85% = \$207.65 Extended Medicare Safety Net Cap: \$36.65	
	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	e
14202	(See para TN.1.16 of explanatory notes to this Category) Fee: \$123.65 Benefit: 75% = \$92.75 Extended Medicare Safety Net Cap: \$18.55	
	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)	i
14203	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) Fee: \$52.75 Benefit: 75% = \$39.60 85% = \$44.85	
	HORMONE OR LIVING TISSUE IMPLANTATION by cannula	
14206	(See para TN.1.4, TN.1.17 of explanatory notes to this Category) Fee: \$36.70 Benefit: 75% = \$27.55 85% = \$31.20	
	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent	
14209	Fee: \$91.45 Benefit: 75% = \$68.60 85% = \$77.75	
	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.)	
14212	Fee: \$191.05 Benefit: 75% = \$143.30 85% = \$162.40	
	IMPLANTED INFUSION PUMP REFILLING OF reservoir, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of chronic intractable pain	
14218	Fee: \$101.00 Benefit: 75% = \$75.75 85% = \$85.85	
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing	of

PROCE	DURES 13. OTHER THERAPEUTIC PROCEDURES	
	not being a service associated with a service to which item 13950 applies	
	Fee: \$54.15 Benefit: 75% = \$40.65 85% = \$46.05	
	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.)	
14224	Fee: \$72.55 Benefit: 75% = \$54.45 85% = \$61.70	
	IMPLANTED INFUSION PUMP, REFILLING of reservoir, with baclofen, for infusion to the subarachnoid or epidural space, with or without re-programming of a programmable pump, for the management of severe chronic spasticity	
14227	(See para TN.1.18 of explanatory notes to this Category) Fee: \$101.00 Benefit: 75% = \$75.75 85% = \$85.85	
	Infusion pump or components of an infusion pump, removal 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.)	
14234	(See para TN.1.18 of explanatory notes to this Category) Fee: \$373.20 Benefit: 75% = \$279.90	
	Infusion pump or components of an infusion pump, subcutaneous implantation of, and intrathecal or epidural spinal catheter insertion, and connection of pump to catheter, and loading of reservoir with baclofen, with or without programming of the pump, for the management of severe chronic spasticity (Anaes.)	
14237	(See para TN.1.18 of explanatory notes to this Category) Fee: \$680.55 Benefit: 75% = \$510.45	
	IMMUNOMODULATING AGENT, administration of, by intravenous infusion for at least 2 hours duration - payable once only on the same day and where the agent is provided under section 100 of the Pharmaceutical Benefits Scheme	
14245	(See para TN.1.19 of explanatory notes to this Category) Fee: \$101.00 Benefit: 75% = \$75.75 85% = \$85.85	
	Extracorporeal photopheresis for the treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if	
	 a. the service is provided in the initial six months of treatment; and b. the service is delivered using an integrated, closed extracorporeal photopheresis system; and c. the patient is 18 years old or over; and d. the patient has received prior systemic treatment for this condition and experienced either disease progression or unacceptable toxicity while on this treatment; and e. the service is provided in combination with the use of Pharmaceutical Benefits Schemesubsidised methoxsalen; and f. the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle	
14247 S		

T1. MISCELLANEOUS THERAPEUTIC **PROCEDURES** 13. OTHER THERAPEUTIC PROCEDURES Fee: \$1.908.35 **Benefit:** 75% = \$1431.30 85% = \$1823.65 Extracorporeal photopheresis for the continuing treatment of erythrodermic stage III-IVa T4 M0 cutaneous T-cell lymphoma; if a. in the preceding 6 months: (i) a service to which item 14247 applies has been provided; and (ii) the patient has demonstrated a response to this service; and (iii) the patient requires further treatment; and b. the service is delivered using an integrated, closed extracorporeal photopheresis system; and c. the patient is 18 years old or over; and d. the service is provided in combination with the use of Pharmaceutical Benefits Schemesubsidised methoxsalen: and e. the service is supervised by a specialist or consultant physician in the speciality of haematology. Applicable once per treatment cycle (See para TN.1.25 of explanatory notes to this Category) **Benefit:** 75% = \$1431.30 85% = \$1823.65 14249 S **Fee:** \$1,908.35 14. MANAGEMENT AND PROCEDURES T1. MISCELLANEOUS THERAPEUTIC **UNDERTAKEN IN AN EMERGENCY PROCEDURES** DEPARTMENT **Group T1. Miscellaneous Therapeutic Procedures** Subgroup 14. Management and Procedures Undertaken in an Emergency Department Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) 14255 Fee: \$153.00 **Benefit:** 75% = \$114.75 85% = \$130.05 Resuscitation of a patient provided for at least 1 hour but less than 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) **Benefit:** 75% = \$220.70 85% = \$250.15 14256 Fee: \$294.25 Resuscitation of a patient provided for at least 2 hours, by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012. 5013, 5014, 5016, 5017 or 5019 (Anaes.) (See para TN.1.24 of explanatory notes to this Category) 14257 **Benefit:** 75% = \$439.50 85% = \$501.30 **Fee:** \$586.00 Resuscitation of a patient provided for at least 30 minutes but less than 1 hour, by a medical practitioner

14258

(except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the

	CELLANEOUS THERAPEUTIC	14. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN EMERGENCY DEPARTMENT
	practitioner described in item 5021, 5022, 5027, 5030,	, 5031, 5032, 5033, 5035 or 5036 (Anaes.)
	(See para TN.1.24 of explanatory notes to this Category) Fee: \$114.80 Benefit: 75% = \$86.10 85% = \$9	7.60
	Resuscitation of a patient provided for at least 1 hour leaves the specialist in the practice of the specialist's specialist generated the specialist's specialist generated the specialist's specialist	pecialty of emergency medicine) at a recognised ction with an attendance on the patient by the
14259	(See para TN.1.24 of explanatory notes to this Category) Fee: \$220.70 Benefit: 75% = \$165.55 85% = \$	187.60
	Resuscitation of a patient provided for at least 2 hours the practice of the specialist's specialty of emergency of a private hospital, in conjunction with an attendance item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035	medicine) at a recognised emergency department e on the patient by the practitioner described in
14260	(See para TN.1.24 of explanatory notes to this Category) Fee: \$439.50 Benefit: 75% = \$329.65 85% = \$	373.60
	Minor procedure on a patient by a specialist in the practice of the specialist's specialty of emergency medicine at a recognised emergency department of a private hospital, in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	
14263	(See para TN.1.24 of explanatory notes to this Category) Fee: \$53.85 Benefit: 75% = \$40.40 85% = \$4	5.80
	Procedure (except a minor procedure) on a patient by specialty of emergency medicine at a recognised emer conjunction with an attendance on the patient by the sponsor, 5013, 5014, 5016, 5017 or 5019 (Anaes.)	gency department of a private hospital, in
14264	(See para TN.1.24 of explanatory notes to this Category) Fee: \$121.25 Benefit: 75% = \$90.95 85% = \$1	03.10
	Minor procedure on a patient by a medical practitioner specialist's specialty of emergency medicine) at a recombine hospital, in conjunction with an attendance on the pating 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (A	ognised emergency department of a private ent by the practitioner described in item 5021,
14265	(See para TN.1.24 of explanatory notes to this Category) Fee: \$40.40 Benefit: 75% = \$30.30 85% = \$3	4.35
	Procedure (except a minor procedure) on a patient by a practice of the specialist's specialty of emergency med private hospital, in conjunction with an attendance on 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 50	dicine) at a recognised emergency department of a the patient by the practitioner described in item
14266	(See para TN.1.24 of explanatory notes to this Category)	7.25

Management, without aftercare, of all fractures and dislocations suffered by a patient that:

(a) is provided by a specialist in the practice of the specialist's specialty of emergency medicine in conjunction with an attendance on the patient by the specialist described in item 5001, 5004, 5011, 5012,

Benefit: 75% = \$68.25 85% = \$77.35

14266

14270

Fee: \$90.95

5013, 5014, 5016, 5017 or 5019; and

T1. MISC PROCED	CELLANEOUS THERAPEUTIC DURES	UNDERTAKEN IN AN EMERGENCY DEPARTMENT
	(b) occurs at a recognised emergency department of a private	hospital (Anaes.)
	(See para TN.1.24 of explanatory notes to this Category) Fee: \$135.95 Benefit: 75% = \$102.00 85% = \$115.60	
	Management, without aftercare, of all fractures and dislocation (a) is provided by a medical practitioner (except a specialist in emergency medicine) in conjunction with an attendance on the item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036 (b) occurs at a recognised emergency department of a private of the second secon	the practice of the specialist's specialty of e patient by the practitioner described in ; and
14272	(See para TN.1.24 of explanatory notes to this Category) Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
	Application of chemical or physical restraint of a patient by a specialty of emergency medicine at a recognised emergency d	
14277	(See para TN.1.24 of explanatory notes to this Category) Fee: \$153.00 Benefit: 75% = \$114.75 85% = \$130.05	
	Application of chemical or physical restraint of a patient by a the practice of the specialist's specialty of emergency medicin of a private hospital	
14278	(See para TN.1.24 of explanatory notes to this Category) Fee: \$114.80 Benefit: 75% = \$86.10 85% = \$97.60	
	Anaesthesia (whether general anaesthesia or not) of a patient to (a) is managed by a specialist in the practice of the specialist's recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, (c) is not anaesthesia provided by a specialist anaesthetist to we	at is described in item 5001, 5004, 5011, 5031, 5032, 5033, 5035 or 5036; and
14280	(See para TN.1.24 of explanatory notes to this Category) Fee: \$153.00 Benefit: 75% = \$114.75 85% = \$130.05	
	Anaesthesia (whether general anaesthesia or not) of a patient to a second is managed by a medical practitioner (except a specialist in emergency medicine) at a recognised emergency department of (b) occurs in conjunction with an attendance on the patient that 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, (c) is not anaesthesia provided by a specialist anaesthetist to we	a the practice of the specialist's specialty of of a private hospital; and at is described in item 5001, 5004, 5011, 5031, 5032, 5033, 5035 or 5036; and
14283	(See para TN.1.24 of explanatory notes to this Category) Fee: \$114.80 Benefit: 75% = \$86.10 85% = \$97.60	
	Emergent intubation, airway management or both of a patient (a) is managed by a specialist in the practice of the specialist's recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, (c) is not anaesthesia provided by a specialist anaesthetist to we	at is described in item 5001, 5004, 5011, 5031, 5032, 5033, 5035 or 5036; and
14285	(See para TN.1.24 of explanatory notes to this Category) Fee: \$153.00 Benefit: 75% = \$114.75 85% = \$130.05	
14288	Emergent intubation, airway management or both of a patient	that:

14. MANAGEMENT AND PROCEDURES

T1. MISCELLANEOUS THERAPEUTIC PROCEDURES

14. MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN EMERGENCY DEPARTMENT

(a) is managed by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) at a recognised emergency department of a private hospital; and (b) occurs in conjunction with an attendance on the patient that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017, 5019, 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and (c) is not anaesthesia provided by a specialist anaesthetist to which an item in Group T7 or T10 applies

(See para TN.1.24 of explanatory notes to this Category)

Fee: \$114.80 **Benefit:** 75% = \$86.10 85% = \$97.60

T2. RAI	DIATION ONCOLOG	Υ	1. SUPERFICIAL
	Group T2. Radiatio	on Oncology	
		Subgroup 1. Su	perficial
	(Benefits for admini	stration of general anaesthetic for rad	diotherapy are payable under Group T10)
		ng a service to which another item in t	with xrays, radium rays or other radioactive this Group applies each attendance at which
	- 1 field		
15000	Fee: \$43.90	Benefit: 75% = \$32.95 85% = \$37.35	5
	not being a service t		s, radium rays or other radioactive substances), oplies - each attendance at which fractionated 5 additional fields
15003	Derived Fee: The fe	ee for item 15000 plus for each field in exc	ess of 1, an amount of \$17.60
	RADIOTHERAPY,	, SUPERFICIAL, attendance at which	single dose technique is applied
	- 1 field		
15006	Fee: \$97.30	Benefit: 75% = \$73.00 85% = \$82.75	5
	Radiotherapy, super a maximum of 5 add		se technique is applied - 2 or more fields up to
15009	Derived Fee: The fe	ee for item 15006 plus for each field in exc	eess of 1, an amount of \$19.15
	RADIOTHERAPY,	, SUPERFICIAL each attendance at w	which treatment is given to an eye
15012	Fee: \$55.10	Benefit: 75% = \$41.35 85% = \$46.85	5
T2. RAI	DIATION ONCOLOG	Y	2. ORTHOVOLTAGE
	Group T2. Radiatio	on Oncology	

T2. RAI	DIATION ONCOLOGY 2. ORTHOVOLTAG
	Subgroup 2. Orthovoltage
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week
	- 1 field
15100	(See para TN.2.1 of explanatory notes to this Category) Fee: \$49.20 Benefit: 75% = \$36.90 85% = \$41.85
	Radiotherapy, deep or orthovoltage each attendance at which fractionated treatment is given at 3 or mor 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 \$19.40
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently
	- 1 field
15106	Fee: \$58.05 Benefit: 75% = \$43.55 85% = \$49.35
	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	Derived Fee: The fee for item 15106 plus for each field in excess of 1, an amount of \$23.40
10105	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field
15112	Fee: \$124.00 Benefit: 75% = \$93.00 85% = \$105.40
	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	Derived Fee: The fee for item 15112 plus for each field in excess of 1, an amount of \$48.75
T2. RAI	DIATION ONCOLOGY 3. MEGAVOLTAG
	Group T2. Radiation Oncology
	Subgroup 3. Megavoltage
	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given
	- 1 field
15211	Fee: \$56.45 Benefit: 75% = \$42.35 85% = \$48.00

T2. RAI	DIATION ONCOLOGY	3. MEGAVOLTAGE	
	Radiation oncology treatment, using cobalt unit or caesium treatment is given 2 or more fields up to a maximum of 5 ad fields)		
15214	Derived Fee: The fee for item 15211 plus for each field in excess	s of 1, an amount of \$32.90	
	RADIATION ONCOLOGY TREATMENT, using a single without electron facilities - each attendance at which treatment primary site (lung)		
15215	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30		
	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	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30		
	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	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15215, 15218 and 15221		
15224	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30		
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site		
15227	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30		
	RADIATION ONCOLOGY TREATMENT, using a single without electron facilities - each attendance at which treatment maximum of 5 additional fields (rotational therapy being 3 f (lung)	ent is given - 2 or more fields up to a	
15230	Derived Fee: The fee for item 15215 plus for each field in excess	s of 1, an amount of \$39.15	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate)		
15233	Derived Fee: The fee for item 15218 plus for each field in excess	s of 1, an amount of \$39.15	
	RADIATION ONCOLOGY TREATMENT, using a single without electron facilities - each attendance at which treatment maximum of 5 additional fields (rotational therapy being 3 f (breast)	ent is given - 2 or more fields up to a	
15236	Derived Fee: The fee for item 15221 plus for each field in excess	s of 1, an amount of \$39.15	
15239	RADIATION ONCOLOGY TREATMENT, using a single without electron facilities - each attendance at which treatments	photon energy linear accelerator with or	

T2. RAI	72. RADIATION ONCOLOGY 3. MEGAVOLT	
	maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15230, 15233 or 15236	
	Derived Fee: The fee for item 15224 plus for each field in excess of 1, an amount of \$39.15	
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site	
15242	Derived Fee: The fee for item 15227 plus for each field in excess of 1, an amount of \$39.15	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung)	
15245	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate)	
15248	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast)	
15251	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for diseases and conditions not covered by items 15245, 15248 or 15251	
15254	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site	
15257	Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30	
	RADIATION ORADIATION ONCOLOGY treatment, using a dual photon energy linear accelerator with a minimum higher energy of at least 10mv photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung)	
15260	Derived Fee: The fee for item 15245 plus for each field in excess of 1, an amount of \$39.15	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate)	
15263	Derived Fee: The fee for item 15248 plus for each field in excess of 1, an amount of \$39.15	
15266	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast)	

T2. RAI	DIATION ONCOLOGY	3. MEGAVOLTAGE	
	Derived Fee: The fee for item 15251 plus for each field in excess of 1, ar	n amount of \$39.15	
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of at least 10MV photons, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for diseases and conditions not covered by items 15260, 15263 or 15266		
15269	Derived Fee: The fee for item 15254 plus for each field in excess of 1, an	n amount of \$39.15	
	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	Derived Fee: The fee for item 15257 plus for each field in excess of 1, an	n amount of \$39.15	
	RADIATION ONCOLOGY TREATMENT with IGRT imaging factors	cilities undertaken:	
	(a) to implement an IMRT dosimetry plan prepared in accordance w	vith item 15565; and	
	(b) utilising an intensity modulated treatment delivery mode (delive linear accelerator or by a helical non C-arm based linear accelerator which treatment is given.		
15275	Fee: \$188.65 Benefit: 75% = \$141.50 85% = \$160.40		
T2. RAI	DIATION ONCOLOGY	4. BRACHYTHERAPY	
	Group T2. Radiation Oncology		
	Subgroup 4. Brachytherapy		
	INTRAUTERINE TREATMENT ALONE using radioactive sealed than 115 days using manual afterloading techniques (Anaes.)	l sources having a half-life greater	
15303	Fee: \$368.15 Benefit: 75% = \$276.15 85% = \$312.95		
	INTRAUTERINE TREATMENT ALONE using radioactive sealed than 115 days using automatic afterloading techniques (Anaes.)	sources having a half-life greater	
15304	Fee: \$368.15 Benefit: 75% = \$276.15 85% = \$312.95		
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.)		
15307	Fee: \$697.95 Benefit: 75% = \$523.50 85% = \$613.25		
	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.)		
15308	Fee: \$697.95 Benefit: 75% = \$523.50 85% = \$613.25		
	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.)		
15311	Fee: \$343.65 Benefit: 75% = \$257.75 85% = \$292.15		

T2. RAI	RADIATION ONCOLOGY 4. BRACHYTHER		
	than 115 days using automatic afterloading techniques (Anaes.)		echniques (Anaes.)
	Fee: \$341.15	Benefit: 75% = \$255.90	85% = \$290.00
			using radioactive sealed sources having a half-life of less n or tantalum using manual afterloading techniques (Anaes.)
15315	Fee: \$674.65	Benefit: 75% = \$506.00	85% = \$589.95
			using radioactive sealed sources having a half-life of less n or tantalum using automatic afterloading techniques
15316	Fee: \$674.65	Benefit: 75% = \$506.00	85% = \$589.95
COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioa sources having a half-life greater than 115 days using manual afterloading techniques (
15319	Fee: \$418.75	Benefit: 75% = \$314.10	85% = \$355.95
			AVAGINAL TREATMENT using radioactive sealed ays using automatic afterloading techniques (Anaes.)
15320	Fee: \$418.75	Benefit: 75% = \$314.10	85% = \$355.95
	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: \$744.55	Benefit: 75% = \$558.45	85% = \$659.85
	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	Fee: \$744.55	Benefit: 75% = \$558.45	85% = \$659.85
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less that including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidura (intrathecal) nerve block, requiring surgical exposure and using manual afterloading technique		to a region, under general anaesthesia, or epidural or spinal
15327	Fee: \$809.95	Benefit: 75% = \$607.50	85% = \$725.25
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.)		
15328	Fee: \$809.95	Benefit: 75% = \$607.50	85% = \$725.25
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.)		
15331	Fee: \$769.10	Benefit: 75% = \$576.85	85% = \$684.40
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical		

T2. RAI	DIATION ONCOLOGY 4. BRACHYTHERAPY
	exposure and using automatic afterloading techniques (Anaes.)
	Fee: \$769.10 Benefit: 75% = \$576.85 85% = \$684.40
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.)
15335	Fee: \$697.95 Benefit: 75% = \$523.50 85% = \$613.25
	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.)
15336	Fee: \$697.95 Benefit: 75% = \$523.50 85% = \$613.25
	Prostate, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance:
	(a) for a patient with:
	(i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate); and
	(ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and
	(iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and
	(b) performed by an oncologist at an approved site in association with a urologist; and
	(c) being a service associated with:
	(i) services to which items 37220 and 55603 apply; and
	(ii) a service to which item 60506 or 60509 applies
15338	(See para TN.2.2 of explanatory notes to this Category) Fee: \$964.80 Benefit: 75% = \$723.60 85% = \$880.10
	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.)
15339	Fee: \$78.55 Benefit: 75% = \$58.95 85% = \$66.80
	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
15342	Fee: \$196.25 Benefit: 75% = \$147.20 85% = \$166.85
	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	Fee: \$523.65 Benefit: 75% = \$392.75 85% = \$445.15
	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance
15348	Fee: \$60.25 Benefit: 75% = \$45.20 85% = \$51.25
15351	CONSTRUCTION WITH OR WITHOUT INITIAL APPLICATION OF RADIOACTIVE MOULD not

T2. RAI	DIATION ONCOLO	OGY	4. BRACHYTHERAPY
	exceeding 5 cm.	diameter to an external surface	
	Fee: \$120.25	Benefit: 75% = \$90.20 85% = \$102.25	
		ON AND INITIAL APPLICATION OF RA	DIOACTIVE MOULD 5 cm. or more in
15354	Fee: \$145.90	Benefit: 75% = \$109.45 85% = \$124.05	5
	radioactive moul	APPLICATIONS OF RADIOACTIVE M d constructed for application to an external a is the first attendance to apply the mould of	
15357	Fee: \$41.30	Benefit: 75% = \$31.00 85% = \$35.15	
T2. RAI	DIATION ONCOLO	OGY	5. COMPUTERISED PLANNING
	Group T2. Radia	tion Oncology	
		Subgroup 5. Computeris	sed Planning
		RADIOTHERAPY PLA	ANNING
	single area for tre		ntric xray or megavoltage machine or CT of a d fields (not being a service associated with a
15500	(See para TN.2.3 o Fee: \$250.25	f explanatory notes to this Category) Benefit: 75% = \$187.70 85% = \$212.75	5
	single area, wher		atric xray or megavoltage machine or CT of a for treatment by multiple fields, or of 2 areas 15512 applies)
15503	(See para TN.2.3 o Fee: \$321.30	f explanatory notes to this Category) Benefit: 75% = \$241.00 85% = \$273.15	5
	or more areas, or irregularly shape	ELD SETTING using a simulator or isocer of total body or half body irradiation, or of d fields using multiple blocks, or of offaxis d with a service to which item 15515 applie	s fields or several joined fields (not being a
15506	(See para TN.2.3 o Fee: \$479.85	f explanatory notes to this Category) Benefit: 75% = \$359.90 85% = \$407.90)
		ELD SETTING using a diagnostic xray unipposed fields (not being a service associated)	
15509	(See para TN.2.3 o Fee: \$216.85	f explanatory notes to this Category) Benefit: 75% = \$162.65	5
	1 plane are requir		it of a single area, where views in more than areas (not being a service associated with a
15512	(See para TN.2.3 o Fee: \$279.60	f explanatory notes to this Category) Benefit: 75% = \$209.70 85% = \$237.70)
15513	RADIATION SO	OURCE LOCALISATION using a simulate	or or x-ray machine or CT of a single area,

T2. RAD	NATION ONCOLOGY 5. COMPUTERISED PLANNING
	where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$316.10 Benefit: 75% = \$237.10 85% = \$268.70
	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies)
15515	(See para TN.2.3 of explanatory notes to this Category) Fee: \$404.80 Benefit: 75% = \$303.60 85% = \$344.10
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks
15518	(See para TN.2.3 of explanatory notes to this Category) Fee: \$79.40 Benefit: 75% = \$59.55 85% = \$67.50
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas or where wedges are used
15521	(See para TN.2.3 of explanatory notes to this Category) Fee: \$350.55 Benefit: 75% = \$262.95 85% = \$298.00
	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields
15524	(See para TN.2.3 of explanatory notes to this Category) Fee: \$657.25 Benefit: 75% = \$492.95 85% = \$572.55
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks
15527	(See para TN.2.3 of explanatory notes to this Category) Fee: \$81.40 Benefit: 75% = \$61.05 85% = \$69.20
	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 areas or where wedges are used
15530	(See para TN.2.3 of explanatory notes to this Category) Fee: \$363.15 Benefit: 75% = \$272.40 85% = \$308.70
	RADIATION DOSIMETRY by a non CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields
15533	(See para TN.2.3 of explanatory notes to this Category) Fee: \$688.60 Benefit: 75% = \$516.45 85% = \$603.90
	BRACHYTHERAPY PLANNING, computerised radiation dosimetry
15536	(See para TN.2.3 of explanatory notes to this Category) Fee: \$275.20 Benefit: 75% = \$206.40 85% = \$233.95
15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338

T2. RAI	DIATION ONCOLOGY	5. COMPUTERISED PLANNING
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$646.90 Benefit: 75% = \$485.20 85%	= \$562.20
	SIMULATION FOR THREE DIMENSIONAL CO contrast medium, where:	NFORMAL RADIOTHERAPY without intravenous
	(a) treatment set up and technique specifications a radiotherapy dose planning; and	are in preparations for three dimensional conformal
	(b) patient set up and immobilisation techniques a acquisition and three dimensional conformal radiot	
	(c) a high-quality CT-image volume dataset must planned and treated; and	be acquired for the relevant region of interest to be
	(d) the image set must be suitable for the generation images	on of quality digitally reconstructed radiographic
15550	(See para TN.2.3 of explanatory notes to this Category) Fee: \$679.20 Benefit: 75% = \$509.40 85%	= \$594.50
	SIMULATION FOR THREE DIMENSIONAL CO intravenous contrast medium, where:	NFORMAL RADIOTHERAPY pre and post
	(a) treatment set up and technique specifications a radiotherapy dose planning; and	re in preparations for three dimensional conformal
	(b) patient set up and immobilisation techniques a acquisition and three dimensional conformal radiot	
	(c) a high-quality CT-image volume dataset must planned and treated; and	be acquired for the relevant region of interest to be
	(d) the image set must be suitable for the generation images	on of quality digitally reconstructed radiographic
15553	(See para TN.2.3 of explanatory notes to this Category) Fee: \$732.75 Benefit: 75% = \$549.60 85%	= \$648.05
	SIMULATION FOR INTENSITY-MODULATED intravenous contrast medium, if:	RADIATION THERAPY (IMRT), with or without
	1. treatment set-up and technique specifications a radiotherapy dose planning; and	re in preparations for three-dimensional conformal
	2. patient set-up and immobilisation techniques a acquisition and three-dimensional conformal radiot	
	3. a high-quality CT-image volume dataset is acq and treated; and	uired for the relevant region of interest to be planned
	4. the image set is suitable for the generation of q	uality digitally-reconstructed radiographic images.
15555	(See para TN.2.3 of explanatory notes to this Category) Fee: \$732.75 Benefit: 75% = \$549.60 85%	= \$648.05
	DOSIMETRY FOR THREE DIMENSIONAL COLCOMPLEXITY where:	NFORMAL RADIOTHERAPY OF LEVEL 1
15556	Com Beautiful mater	

T2. RADIATION ONCOLOGY

5. COMPUTERISED PLANNING

- (a) dosimetry for a single phase three dimensional conformal treatment plan using CT image volume dataset and having a single treatment target volume and organ at risk; and
- (b) one gross tumour volume or clinical target volume, plus one planning target volume plus at least one relevant organ at risk as defined in the prescription must be rendered as volumes; and
- (c) the organ at risk must be nominated as a planning dose goal or constraint and the prescription must specify the organ at risk dose goal or constraint; and
- (d) dose volume histograms must be generated, approved and recorded with the plan; and
- (e) a CT image volume dataset must be used for the relevant region to be planned and treated; and
- (f) the CT images must be suitable for the generation of quality digitally reconstructed radiographic images

(See para TN.2.3 of explanatory notes to this Category)

Fee: \$685.20 **Benefit:** 75% = \$513.90 85% = \$600.50

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:** \$893.60 **Benefit:** 75% = \$670.20 85% = \$808.90

DOSIMETRY FOR THREE DIMENSIONAL CONFORMAL RADIOTHERAPY OF LEVEL 3 COMPLEXITY - where:

- (a) dosimetry for a three or more phase three dimensional conformal treatment plan using CT image volume dataset(s) with at least one gross tumour volume, three planning target volumes and one organ at risk defined in the prescription; or
- (b) dosimetry for a two phase three dimensional conformal treatment plan using CT image volume datasets with at least one gross tumour volume, and

15562

T2. RADIATION ONCOLOGY

5. COMPUTERISED PLANNING

- (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;

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(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: \$1,155.80 **Benefit:** 75% = \$866.85 85% = \$1071.10

Preparation of an IMRT DOSIMETRY PLAN, which uses one or more CT image volume datasets, if:

- (a) in preparing the IMRT dosimetry plan:
 - (i) the differential between target dose and normal tissue dose is maximised, based on a review and assessment by a radiation oncologist; and
 - (ii) all gross tumour targets, clinical targets, planning targets and organs at risk are rendered as volumes as defined in the prescription; and
 - (iii) organs at risk are nominated as planning dose goals or constraints and the prescription specifies the organs at risk as dose goals or constraints; and
 - (iv) dose calculations and dose volume histograms are generated in an inverse planned process, using a specialised calculation algorithm, with prescription and plan details approved and recorded in the plan; and
 - (v) a CT image volume dataset is used for the relevant region to be planned and treated; and
 - (vi) the CT images are suitable for the generation of quality digitally reconstructed radiographic images; and
- (b) the final IMRT dosimetry plan is validated by the radiation therapist and the medical physicist, using robust quality assurance processes that include:
 - (i) determination of the accuracy of the dose fluence delivered by the multi-leaf collimator and gantryposition (static or dynamic); and
- (ii) ensuring that the plan is deliverable, data transfer is acceptable and validation checks are

T2. RAI	DIATION ONCOLOGY 5. COMPUTERISED PLANNING
	completed on a linear accelerator; and
	(iii) validating the accuracy of the derived IMRT dosimetry plan; and
	(c) the final IMRT dosimetry plan is approved by the radiation oncologist prior to delivery.
	(See para TN.2.3 of explanatory notes to this Category) Fee: \$3,417.35 Benefit: 75% = \$2563.05 85% = \$3332.65
T2. RAI	DIATION ONCOLOGY 6. STEREOTACTIC RADIOSURGER
	Group T2. Radiation Oncology
	Subgroup 6. Stereotactic Radiosurgery
	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment
15600	Fee: \$1,755.50 Benefit: 75% = \$1316.65 85% = \$1670.80
T2. RAI	7. RADIATION ONCOLOGY TREATMEN VERIFICATION
	Group T2. Radiation Oncology
	Subgroup 7. Radiation Oncology Treatment Verification
	RADIATION ONCOLOGY TREATMENT VERIFICATION - single projection (with single or double exposures) - when prescribed and reviewed by a radiation oncologist and not associated with item 1570 or 15710 - each attendance at which treatment is verified (ie maximum one per attendance).
15700	(See para TN.2.4 of explanatory notes to this Category) Fee: \$47.40 Benefit: 75% = \$35.55 85% = \$40.30
	RADIATION ONCOLOGY TREATMENT VERIFICATION - multiple projection acquisition when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15710 - each attendance at which treatment involving three or more fields is verified (ie maximum one per attendance).
15705	(See para TN.2.4 of explanatory notes to this Category) Fee: \$79.00 Benefit: 75% = \$59.25 85% = \$67.15
	RADIATION ONCOLOGY TREATMENT VERIFICATION - volumetric acquisition, when prescribed and reviewed by a radiation oncologist and not associated with item 15700 or 15705 - each attendance at which treatment involving three fields or more is verified (ie maximum one per attendance).
	(see para T2.5 of explanatory notes to this Category)
15710	(See para TN.2.4 of explanatory notes to this Category) Fee: \$79.00 Benefit: 75% = \$59.25 85% = \$67.15
	RADIATION ONCOLOGY TREATMENT VERIFICATION of planar or volumetric IGRT for IMRT, involving the use of at least 2 planar image views or projections or 1 volumetric image set to facilitate a 3-dimensional adjustment to radiation treatment field positioning, if:
	(a) the treatment technique is classified as IMRT; and
15715	(b) the margins applied to volumes (clinical target volume or planning target volume) are tailored or

7. RADIATION ONCOLOGY TREATMENT T2. RADIATION ONCOLOGY **VERIFICATION** 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) **Benefit:** 75% = \$59.25 85% = \$67.15 Fee: \$79.00 8. BRACHYTHERAPY PLANNING AND T2. RADIATION ONCOLOGY VERIFICATION **Group T2. Radiation Oncology** Subgroup 8. Brachytherapy Planning And Verification BRACHYTHERAPY TREATMENT VERIFICATION - maximum of one only for each attendance. (See para TN.2.4 of explanatory notes to this Category) 15800 Fee: \$99.30 **Benefit:** 75% = \$74.50 85% = \$84.45 RADIATION SOURCE LOCALISATION using a simulator, x-ray machine, CT or ultrasound of a single area, where views in more than one plane are required, for brachytherapy treatment planning, not being a service to which Item 15513 applies. 15850 Fee: \$205.75 **Benefit:** 75% = \$154.35 85% = \$174.90 10. TARGETED INTRAOPERATIVE T2. RADIATION ONCOLOGY **RADIOTHERAPY Group T2. Radiation Oncology** Subgroup 10. Targeted Intraoperative Radiotherapy INTRAOPERATIVE RADIOTHERAPY BREAST, MALIGNANT TUMOUR, targeted intraoperative radiation therapy, using an Intrabeam® or Xoft® Axxent® device, delivered at the time of breast-conserving surgery (partial mastectomy or lumpectomy) for a patient who: Amend 15900

T2. RAI	10. TARGETED INTRAOPERATIVE RADIOTHERAPY
	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
	Applicable only once per breast per lifetime (H)
	Fee: \$257.80 Benefit: 75% = \$193.35
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) Fee: \$670.80 Benefit: 75% = \$503.10 85% = \$586.10
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique
16006	Fee: \$515.45 Benefit: 75% = \$386.60 85% = \$438.15
	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique
16009	Fee: \$351.80 Benefit: 75% = \$263.85 85% = \$299.05
	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32
16012	Fee: \$304.35 Benefit: 75% = \$228.30 85% = \$258.70
	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either:
	(i) the disease is poorly controlled by conventional radiotherapy; or
	(ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain
16015	Fee: \$4,213.30 Benefit: 75% = \$3160.00 85% = \$4128.60
	ADMINISTRATION OF ¹⁵³ SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) where hormonal therapy and/or chemotherapy have failed and either the disease is poorly controlled by conventional radiotherapy or conventional radiotherapy is
	inappropriate, due to the wide distribution of sites of bone pain.

T4. OB	STETRICS
	Group T4. Obstetrics
	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if:
	(a) the attendance is by video conference; and
	(b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and
	(c) the patient is not an admitted patient; and
	(d) the patient:
	(i) is located both:
	(A) within a telehealth eligible area; and
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies
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: \$24.65
	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
	(See para TN.4.1, TN.4.15 of explanatory notes to this Category)
16400	Fee: \$28.10 Benefit: 85% = \$23.90 Extended Medicare Safety Net Cap: \$11.35
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each attendance, other than a second or subsequent attendance in a single course of treatment
16401	(See para TN.4.2 of explanatory notes to this Category) Fee: \$88.20 Benefit: 75% = \$66.15 85% = \$75.00 Extended Medicare Safety Net Cap: \$56.20
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment.
16404	(See para AN.0.70, TN.4.2 of explanatory notes to this Category) Fee: \$44.35 Benefit: 75% = \$33.30 85% = \$37.70 Extended Medicare Safety Net Cap: \$33.75

T4. OB	STETRICS
	Antenatal professional attendance, by an obstetrician or general practitioner, as part of a single course of treatment when the patient is referred by a participating midwife. Payable only once for a pregnancy
16406	Fee: \$138.15 Benefit: 75% = \$103.65 85% = \$117.45 Extended Medicare Safety Net Cap: \$110.65
	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, TN.4.15 of explanatory notes to this Category) Fee: \$73.95 Benefit: 75% = \$55.50 85% = \$62.90 Extended Medicare Safety Net Cap: \$48.10
	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
	(See para TN.4.15 of explanatory notes to this Category)
16408	Fee: \$55.05 Benefit: 85% = \$46.80 Extended Medicare Safety Net Cap: \$35.80
	ANTENATAL ATTENDANCE
	(See para TN.4.3, TN.4.15 of explanatory notes to this Category) Fee: \$48.60 Benefit: 75% = \$36.45 85% = \$41.35
16500	Extended Medicare Safety Net Cap: \$33.75
16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication

T4. OB	STETRICS
	exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy
	(See para TN.4.3, TN.4.4 of explanatory notes to this Category) Fee: \$144.95 Benefit: 75% = \$108.75 85% = \$123.25 Extended Medicare Safety Net Cap: \$67.40
	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day
16502	(See para TN.4.3 of explanatory notes to this Category) Fee: \$48.60
	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance
16505	(See para TN.4.3 of explanatory notes to this Category) Fee: \$48.60 Benefit: 75% = \$36.45 85% = \$41.35 Extended Medicare Safety Net Cap: \$22.50
	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each professional attendance (other than a service to which item 16533 applies) that is not a routine antenatal attendance, to a maximum of one visit per day
16508	(See para TN.4.3 of explanatory notes to this Category) Fee: \$48.60 Benefit: 75% = \$36.45 85% = \$41.35 Extended Medicare Safety Net Cap: \$22.50
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of - each professional attendance (other than a service to which item 16534 applies) that is not a routine antenatal attendance
16509	(See para TN.4.3 of explanatory notes to this Category) Fee: \$48.60 Benefit: 75% = \$36.45 85% = \$41.35 Extended Medicare Safety Net Cap: \$22.50
	CERVIX, purse string ligation of (Anaes.) (See para TN.4.3 of explanatory notes to this Category)
16511	Fee: \$226.80 Benefit: 75% = \$170.10 85% = \$192.80 Extended Medicare Safety Net Cap: \$112.30
	CERVIX, removal of purse string ligature of (Anaes.) (See para TN.4.3 of explanatory notes to this Category)
16512	Fee: \$65.45 Benefit: 75% = \$49.10 85% = \$55.65 Extended Medicare Safety Net Cap: \$33.75
	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)
16514	(See para TN.4.3 of explanatory notes to this Category) Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15 Extended Medicare Safety Net Cap: \$16.90
16515	Management of vaginal birth as an independent procedure, if the patient's care has been transferred by

T4. OBS	T4. OBSTETRICS	
	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.)	
	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$650.55 Benefit: 75% = \$487.95 85% = \$565.85 Extended Medicare Safety Net Cap: \$179.65	
	Management of labour, incomplete, if the patient's care has been transferred to another medical practitioner for completion of the birth (Anaes.)	
16518	(See para TN.4.5, TN.4.10 of explanatory notes to this Category) Fee: \$464.70 Benefit: 75% = \$348.55 85% = \$395.00 Extended Medicare Safety Net Cap: \$179.65	
	Management of labour and birth by any means (including Caesarean section) including post-partum care for 5 days (Anaes.)	
16519	(See para TN.4.5, TN.4.6, TN.4.10 of explanatory notes to this Category) Fee: \$715.65 Benefit: 75% = \$536.75 85% = \$630.95 Extended Medicare Safety Net Cap: \$336.75	
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)	
16520	(See para TN.4.6, TN.4.10 of explanatory notes to this Category) Fee: \$650.55 Benefit: 75% = \$487.95 85 % = \$565.85 Extended Medicare Safety Net Cap: \$336.75	
	Management of labour and birth, or birth alone, (including caesarean section), on or after 23 weeks gestation, if in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for 7 days:	
	(a) fetal loss;	
	(b) multiple pregnancy;	
	(c) antepartum haemorrhage that is:	
	(i) of greater than 200 ml; or	
	(ii) associated with disseminated intravascular coagulation;	
	(d) placenta praevia on ultrasound in the third trimester with the placenta within 2 cm of the internal cervical os;	
	(e) baby with a birth weight less than or equal to 2,500 g;	
	(f) trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section;	
	(g) trial of vaginal breech birth where there has been a planned vaginal breech birth;	
	(h) prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3 cm cervical dilatation and effacement until full dilatation of the cervix);	
16522	(i) acute fetal compromise evidenced by:	

T4. OBSTETRICS

- (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 150×10^9 /L; or
 - (iv) uric acid greater than 0.36 mmol/L;
- (1) gestational diabetes mellitus requiring at least daily blood glucose monitoring;
- (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by:
 - (i) the patient requiring hospitalisation; or
 - (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or
 - (iii) the patient having a GP mental health treatment plan; or
 - (iv) the patient having a management plan prepared in accordance with item 291;
- (n) disclosure or evidence of domestic violence;
- (o) any of the following conditions either diagnosed pre-pregnancy or evident at the first antenatal visit before 20 weeks gestation:
 - (i) pre-existing hypertension requiring antihypertensive medication prior to pregnancy;
 - (ii) cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);
 - (iii) previous renal or liver transplant;
 - (iv) renal dialysis;
 - (v) chronic liver disease with documented oesophageal varices;

T4. OBS	STETRICS
	(vi) renal insufficiency in early pregnancy (serum creatinine greater than 110 mmol/L);
	(vii) neurological disorder that confines the patient to a wheelchair throughout pregnancy;
	(viii) maternal height of less than 148 cm;
	(ix) a body mass index greater than or equal to 40;
	(x) pre-existing diabetes mellitus on medication prior to pregnancy;
	(xi) thyrotoxicosis requiring medication;
	(xii) previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium;
	(xiii) thrombocytopenia with platelet count of less than 100,000 prior to 20 weeks gestation;
	(xiv) HIV, hepatitis B or hepatitis C carrier status positive;
	(xv) red cell or platelet iso-immunisation;
	(xvi) cancer with metastatic disease;
	(xvii) illicit drug misuse during pregnancy (Anaes.)
	(See para TN.4.7 of explanatory notes to this Category) Fee: \$1,680.25 Benefit: 75% = \$1260.20
	Management of vaginal birth, if the patient's care has been transferred by a participating midwife for management of the birth, including all attendances related to the birth. Payable once only for a pregnancy.
	(Anaes.)
16527	(See para TN.4.8 of explanatory notes to this Category) Fee: \$650.55 Benefit: 75% = \$487.95 Extended Medicare Safety Net Cap: \$179.65
	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.)
16528	(See para TN.4.8 of explanatory notes to this Category) Fee: \$650.55 Benefit: 75% = \$487.95 Extended Medicare Safety Net Cap: \$336.75
	Management of pregnancy loss, from 14 weeks to 15 weeks and 6 days gestation, other than a service to which item 16531, 35640 or 35643 applies (Anaes.)
16530	(See para TN.4.5 of explanatory notes to this Category) Fee: \$396.35 Benefit: 75% = \$297.30 85% = \$336.90 Extended Medicare Safety Net Cap: \$257.65
	Management of pregnancy loss, from 16 weeks to 22 weeks and 6 days gestation, other than a service to which item 16530, 35640 or 35643 applies (Anaes.)
16531	(See para TN.4.5, TN.4.14 of explanatory notes to this Category) Fee: \$792.70 Benefit: 75% = \$594.55
16533	Pregnancy complicated by acute intercurrent infection, fetal growth restriction, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy,

T4. OB	STETRICS
	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
	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$108.85 Benefit: 75% = \$81.65
	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each professional attendance lasting at least 40 minutes that is not a routine antenatal attendance, to a maximum of 3 services per pregnancy
16534	(See para TN.4.3, TN.4.14 of explanatory notes to this Category) Fee: \$108.85 Benefit: 75% = \$81.65
	POST-PARTUM CARE EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)
16564	(See para TN.4.10 of explanatory notes to this Category) Fee: \$224.80 Benefit: 75% = \$168.60 85% = \$191.10 Extended Medicare Safety Net Cap: \$224.50
	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.)
16567	(See para TN.4.10 of explanatory notes to this Category) Fee: \$328.75 Benefit: 75% = \$246.60 85% = \$279.45 Extended Medicare Safety Net Cap: \$224.50
	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.)
16570	(See para TN.4.10 of explanatory notes to this Category) Fee: \$429.05 Benefit: 75% = \$321.80 85 % = \$364.70 Extended Medicare Safety Net Cap: \$224.50
	CERVIX, repair of extensive laceration or lacerations (Anaes.)
16571	(See para TN.4.10 of explanatory notes to this Category) Fee: \$328.75 Benefit: 75% = \$246.60 85% = \$279.45 Extended Medicare Safety Net Cap: \$224.50
	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)
16573	(See para TN.4.10 of explanatory notes to this Category) Fee: \$267.90 Benefit: 75% = \$200.95 85% = \$227.75 Extended Medicare Safety Net Cap: \$224.50
	Planning and management, by a practitioner, of a pregnancy if:
	(a) the practitioner intends to take primary responsibility for management of the pregnancy and any complications, and to be available for the birth; and
	(b) the patient intends to be privately admitted for the birth; and
	(c) the pregnancy has progressed beyond 28 weeks gestation; and
	(d) the practitioner has maternity privileges at a hospital or birth centre; and
16590	(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) Fee: \$384.40 Benefit: 75% = \$288.30 85% = \$326.75 Extended Medicare Safety Net Cap: \$224.50		
Planning and management, by a practitioner, of a pregnancy if:		
(a) the pregnancy has progressed beyond 28 weeks gestation; and		
(b) the service includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and		
(c) a service to which item 16590 applies is not provided in relation to the same pregnancy		
Payable once only for a pregnancy		
(See para TN.4.13, TN.4.9 of explanatory notes to this Category) Fee: \$147.10 Benefit: 75% = \$110.35 85% = \$125.05 Extended Medicare Safety Net Cap: \$112.30		
INTERVENTIONAL TECHNIQUES		
AMNIOCENTESIS, diagnostic		
(See para TN.4.11, TN.4.3 of explanatory notes to this Category)		
Fee: \$65.45 Benefit: 75% = \$49.10 85% = \$55.65		
Extended Medicare Safety Net Cap: \$33.75 CHORIONIC VILLUS SAMPLING, by any route		
· ·		
(See para TN.4.11, TN.4.3 of explanatory notes to this Category)		
Fee: \$125.65 Benefit: 75% = \$94.25 85% = \$106.85 Extended Medicare Safety Net Cap: \$67.40		
Fetal blood sampling, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.)		
(See para TN.4.11, TN.4.3 of explanatory notes to this Category)		
Fee: \$250.85 Benefit: 75% = \$188.15 85% = \$213.25 Extended Medicare Safety Net Cap: \$134.80		
FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including		
neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.)		
(See para TN.4.11, TN.4.3 of explanatory notes to this Category)		
Fee: \$511.50 Benefit: 75% = \$383.65 85% = \$434.80 Extended Medicare Safety Net Cap: \$258.25		
FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including		
neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a		

T4. OBS	STETRICS		
	service described in item 16609 (Anaes.)		
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$402.45 Benefit: 75% = \$301.85 85% = \$342.10		
	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.)		
16615	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$214.35 Benefit: 75% = \$160.80 85% = \$182.20		
	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated		
1.5510	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$214.35 Benefit: 75% = \$160.80 85% = \$182.20		
16618	Extended Medicare Safety Net Cap: \$106.70		
	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios		
16621	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$214.35 Benefit: 75% = \$160.80 85% = \$182.20		
16621	FOETAL FLUID FILLED CAVITY, drainage of		
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category)		
16624	Fee: \$308.45 Benefit: 75% = \$231.35 85% = \$262.20 Extended Medicare Safety Net Cap: \$145.95		
	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis		
	(See para TN.4.11, TN.4.3 of explanatory notes to this Category) Fee: \$628.00 Benefit: 75% = \$471.00 85% = \$543.30		
16627	Extended Medicare Safety Net Cap: \$314.35		
T4. OB	1. COVID-19 OBSTETRIC TELEHEALTH STETRICS SERVICES		
	Group T4. Obstetrics		
	Subgroup 1. COVID-19 Obstetric Telehealth Services		
	Antenatal telehealth service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if:		
	(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and		
	(b) the service is provided at, or from, a practice location in a regional, rural or remote area; and		
	(c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner.		
91850	Fee: \$28.10 Benefit: 85% = \$23.90		

1. COVID-19 OBSTETRIC TELEHEALTH **T4. OBSTETRICS SERVICES** any other item applies) if: is between 4 and 8 weeks after the birth; and lasts at least 20 minutes in duration; and includes a mental health assessment (including screening for drug and alcohol use and domestic violence) of the patient; and (d) is for a pregnancy in relation to which a service to which item 82140 applies is not provided. Applicable once for a pregnancy Fee: \$73.95 **Benefit:** 85% = \$62.90Postnatal telehealth 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: (a) the attendance is rendered by: a midwife (on behalf of and under the supervision of the medical practitioner who attended (i) the birth); or (ii) an obstetrician: or (iii) a general practitioner; and is between 1 week and 4 weeks after the birth; and lasts at least 20 minutes; and is for a patient who was privately admitted for the birth; and is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided. Applicable once for a pregnancy 91852 Fee: \$55.05 **Benefit:** 85% = \$46.80Antenatal telehealth attendance. 91853 Fee: \$48.60 **Benefit:** 85% = \$41.35T4. OBSTETRICS 2. COVID-19 OBSTETRIC PHONE SERVICES

T4. OBS	TETRICS 2. COVID-19 OBSTETRIC PHONE SERVICES			
	Group T4. Obstetrics			
	Subgroup 2. COVID-19 Obstetric Phone Services			
	Antenatal phone service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner, to a maximum of 10 services per pregnancy, if:			
	(a) the service is provided on behalf of, and under the supervision of, a medical practitioner; and			
	(b) the service is provided at, or from, a practice location in a regional, rural or remote area; and			
	(c) the service is not performed in conjunction with another antenatal attendance item in Group T4 for the same patient on the same day by the same practitioner.			
91855	Fee: \$28.10 Benefit: 85% = \$23.90			
	Postnatal phone attendance by an obstetrician or general practitioner (other than a service to which any other item applies) if:			
	(a) is between 4 and 8 weeks after the birth; and			
	(b) lasts at least 20 minutes in duration; and			
	(c) includes a mental health assessment (including screening for drug and alcohol use and domeviolence) of the patient; and			
	(d) is for a pregnancy in relation to which a service to which item 82140 applies is not provided.			
	Applicable once for a pregnancy			
91856	Fee: \$73.95 Benefit: 85% = \$62.90			
	Postnatal phone 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:			
	(a) the attendance is rendered 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			
91857	(d) is for a patient who was privately admitted for the birth; and			

T4. OB	STETRICS 2. COVID-19 OBSTETRIC PHONE SERVICES
	(e) is for a pregnancy in relation to which a service to which item 82130, 82135 or 82140 applies is not provided.
	Applicable once for a pregnancy
	Fee: \$55.05 Benefit: 85% = \$46.80
	Antenatal phone attendance.
91858	Fee: \$48.60 Benefit: 85% = \$41.35
T6. AN	AESTHETICS 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
	(B) at the time of the attendance-at least 15 kms by road from the specialist; or
	(ii) is a care recipient in a residential care service; or
	(iii) is a patient of:
	(A) an Aboriginal Medical Service; or
	(B) an Aboriginal Community Controlled Health Service;
	for which a direction made under subsection 19 (2) of the Act applies
	(See para TN.6.4 of explanatory notes to this Category) Derived Fee: 50% of the fee for item 17610, 17615, 17620, 17625, 17640, 17645, 17650, or 17655. Benefit: 85% of the derived fee
17609	Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or \$500.00, whichever is the lesse amount
	ANAESTHETIST, PRE-ANAESTHESIA CONSULTATION
17610	

T6. ANA	ESTHETICS 1. ANAESTHESIA CONSULTATIONS
	(Professional attendance by a medical practitioner in the practice of ANAESTHESIA)
	 a BRIEF consultation involving a targeted history and limited examination (including the cardio-respiratory system)
	 AND of not more than 15 minutes s duration, not being a service associated with a service to which items 2801 - 3000 apply
	(See para TN.6.1 of explanatory notes to this Category) Fee: \$45.00 Benefit: 75% = \$33.75 85% = \$38.25 Extended Medicare Safety Net Cap: \$135.00
	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems, involving a selective history and an extensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 15 minutes but not more than 30 minutes duration, not being a service associated with a service to which items 2801 - 3000 applies
17615	(See para TN.6.1 of explanatory notes to this Category) Fee: \$89.55 Benefit: 75% = \$67.20 85% = \$76.15 Extended Medicare Safety Net Cap: \$268.65
	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving a detailed history and comprehensive examination of multiple systems and the formulation of a written patient management plan documented in the patient notes - and of more than 30 minutes but not more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply
17620	(See para TN.6.1 of explanatory notes to this Category) Fee: \$124.05 Benefit: 75% = \$93.05 Extended Medicare Safety Net Cap: \$372.15
	Professional attendance by a medical practitioner in the practice of anaesthesia for a consultation on a patient undergoing advanced surgery or who has complex medical problems involving an exhaustive history and comprehensive examination of multiple systems, the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity documented in the patient notes - and of more than 45 minutes duration, not being a service associated with a service to which items 2801 - 3000 apply
17625	(See para TN.6.1 of explanatory notes to this Category) Fee: \$157.95 Benefit: 75% = \$118.50 85% = \$134.30 Extended Medicare Safety Net Cap: \$473.85
11023	ANAESTHETIST, REFERRED CONSULTATION (other than prior to anaesthesia)
17640	(Professional attendance by a specialist anaesthetist in the practice of ANAESTHESIA where the patient is referred to him or her)

T6. ANA	AESTHETICS 1. ANAESTHESIA CONSULTATIONS
	- 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
	(See para TN.6.2 of explanatory notes to this Category) Fee: \$45.00 Benefit: 75% = \$33.75 85% = \$38.25 Extended Medicare Safety Net Cap: \$135.00
	- 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: \$89.55 Benefit: 75% = \$67.20 85% = \$76.15 Extended Medicare Safety Net Cap: \$268.65
	- 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) Fee: \$124.05 Benefit: 75% = \$93.05 Extended Medicare Safety Net Cap: \$372.15
	- a consultation involving an exhaustive history and comprehensive examination of multiple systems and the formulation of a written patient management plan following discussion with relevant health care professionals and/or the patient, involving medical planning of high complexity,
	- <i>AND of more than 45 minutes duration</i> , not being a service associated with a service to which items 2801 - 3000 apply.
17655	(See para TN.6.2 of explanatory notes to this Category) Fee: \$157.95 Benefit: 75% = \$118.50 Extended Medicare Safety Net Cap: \$473.85
17033	ANAESTHETIST, CONSULTATION, OTHER
	(Professional attendance by an anaesthetist in the practice of ANAESTHESIA)
17680	

T6. AN	NAESTHETICS 1. A	NAESTHESIA CONSULTATION
	- a consultation immediately prior to the institution of a major reg where no previous anaesthesia consultation has occurred, not being which items 2801 - 3000 apply.	
	(See para TN.6.3 of explanatory notes to this Category) Fee: \$89.55 Benefit: 75% = \$67.20 85% = \$76.15 Extended Medicare Safety Net Cap: \$268.65	
	- Where a pre-anaesthesia consultation covered by an item in the rooms if:	e range 17615-17625 is performed in-
	(a) the service is provided to a patient prior to an admitted patient eand	episode of care involving anaesthesia
	(b) the service is not provided to an admitted patient of a hospital;	and
	(c) the service is not provided on the day of admission to hospital f involving anaesthesia services; and	or the subsequent episode of care
	(d) the service is of more than 15 minutes duration	
	not being a service associated with a service to which items 2801 - (See para TN.6.3 of explanatory notes to this Category) Fee: \$41.40 Benefit: 75% = \$31.05 85% = \$35.20	3000 apply.
17690	Extended Medicare Safety Net Cap: \$124.20	
T7. RE0	EGIONAL OR FIELD NERVE BLOCKS	_
	Group T7. Regional Or Field Nerve Blocks	
	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrogr	rade perfusion
18213	Fee: \$91.40 Benefit: 75% = \$68.55 85% = \$77.70	
	Intrathecal, combined spinal-epidural or epidural infusion of a there commencement of, including up to 1 hour of continuous attendance	
	Applicable once per presentation, per medical practitioner, per com	nplete new procedure (Anaes.)
18216	(See para TN.10.7 of explanatory notes to this Category) Fee: \$195.85 Benefit: 75% = \$146.90 85% = \$166.50	
	Intrathecal, combined spinal-epidural or epidural infusion of a there commencement of, if continuous attendance by the medical practition (Appell)	

(Anaes.)

	Derived Fee: The fee for item 18216 plus \$19.60 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) Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00	
	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) Fee: \$51.60 Benefit: 75% = \$38.70 85% = \$43.90	
	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) Fee: \$293.70 Benefit: 75% = \$220.30 85% = \$249.65	
	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.	
18227	(See para TN.7.4, TN.10.7 of explanatory notes to this Category) Derived Fee: The fee for item 18226 plus \$29.50 for each additional 15 minutes or part there of beyond the first hour of attendance by the medical practitioner.	
	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance	
18228	Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80	
	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.)	
18230	Fee: \$245.90 Benefit: 75% = \$184.45 85% = \$209.05	
	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.)	
18232	(See para TN.7.3 of explanatory notes to this Category) Fee: \$195.85 Benefit: 75% = \$146.90 85% = \$166.50	
	EPIDURAL INJECTION of blood for blood patch (Anaes.)	
18233	Fee: \$195.85 Benefit: 75% = \$146.90 85% = \$166.50	
10233	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.)	
	(See para TN.7.5 of explanatory notes to this Category)	
18234	Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45 TRIGEMINAL NERVE, peripheral breach of injection of an appasthatic agent (Appas)	
	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.)	
18236	(See para TN.7.5 of explanatory notes to this Category)	

	Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80		
	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies		
18238	(See para TN.7.5 of explanatory notes to this Category) Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00		
	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent		
18240	(See para TN.7.5 of explanatory notes to this Category) Fee: \$96.55 Benefit: 75% = \$72.45 85% = \$82.10		
	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.)		
18242	(See para TN.7.5 of explanatory notes to this Category) Fee: \$38.80 Benefit: 75% = \$29.10 85% = \$33.00		
	VAGUS NERVE, injection of an anaesthetic agent		
18244	(See para TN.7.5 of explanatory notes to this Category) Fee: \$103.95 Benefit: 75% = \$78.00 85% = \$88.40		
10244	PHRENIC NERVE, injection of an anaesthetic agent		
18248	(See para TN.7.5 of explanatory notes to this Category) Fee: \$91.40 Benefit: 75% = \$68.55 85% = \$77.70		
	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent		
18250	(See para TN.7.5 of explanatory notes to this Category) Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80		
10230	CERVICAL PLEXUS, injection of an anaesthetic agent		
18252	(See para TN.7.5 of explanatory notes to this Category) Fee: \$103.95 Benefit: 75% = \$78.00 85% = \$88.40		
	BRACHIAL PLEXUS, injection of an anaesthetic agent		
	(See para TN.7.5 of explanatory notes to this Category)		
18254	(See para 1N.7.5 of explanatory notes to this Category) Fee: $$103.95$ Benefit: $75\% = 78.00 $85\% = 88.40		
	SUPRASCAPULAR NERVE, injection of an anaesthetic agent		
	(See para TN.7.5 of explanatory notes to this Category)		
18256	Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80		
	INTERCOSTAL NERVE (single), injection of an anaesthetic agent		
18258	(See para TN.7.5 of explanatory notes to this Category) Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80		
	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent		
18260	(See para TN.7.5 of explanatory notes to this Category) Fee: \$91.40 Benefit: 75% = \$68.55 85% = \$77.70		
	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection an anaesthetic agent (Anaes.)		
18262	(See para TN.7.5 of explanatory notes to this Category) Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80		

T7. RE0	GIONAL OR FIELD NERVE BLOCKS		
	PUDENDAL NERVE and or dorsal nerve, injection of anaesthetic agent		
18264	(See para TN.7.5 of explanatory notes to this Category) Fee: \$103.95 Benefit: 75% = \$78.00 85% = \$88.40		
	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		
18266	(See para TN.7.5 of explanatory notes to this Category) Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80		
	OBTURATOR NERVE, injection of an anaesthetic agent		
18268	(See para TN.7.5 of explanatory notes to this Category) Fee: \$91.40 Benefit: 75% = \$68.55 85% = \$77.70		
	FEMORAL NERVE, injection of an anaesthetic agent		
18270	(See para TN.7.5 of explanatory notes to this Category) Fee: \$91.40 Benefit: 75% = \$68.55 85% = \$77.70		
	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent		
18272	(See para TN.7.5 of explanatory notes to this Category) Fee: \$64.45 Benefit: 75% = \$48.35 85% = \$54.80		
	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level)		
18274	(See para TN.7.5 of explanatory notes to this Category) Fee: \$91.40 Benefit: 75% = \$68.55 85% = \$77.70		
	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels)		
18276	(See para TN.7.5 of explanatory notes to this Category) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45		
	SCIATIC NERVE, injection of an anaesthetic agent		
18278	(See para TN.7.5 of explanatory notes to this Category) Fee: \$91.40 Benefit: 75% = \$68.55 85% = \$77.70		
	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.)		
18280	(See para TN.7.5 of explanatory notes to this Category) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45		
	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure		
18282	(See para TN.7.5 of explanatory notes to this Category) Fee: \$103.95 Benefit: 75% = \$78.00 85% = \$88.40		
	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.)		
18284	(See para TN.7.5 of explanatory notes to this Category) Fee: \$152.25 Benefit: 75% = \$114.20 85% = \$129.45		
	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.)		
18286	(See para TN.7.5 of explanatory notes to this Category) Fee: \$152.25 Benefit: 75% = \$114.20 85% = \$129.45		

T7. REC	GIONAL OR FIELD NERVE BLOCKS	
	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.)	
18288	(See para TN.7.5 of explanatory notes to this Category) Fee: \$152.25 Benefit: 75% = \$114.20 85% = \$129.45	
	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.)	
18290	Fee: \$257.55 Benefit: 75% = \$193.20 85% = \$218.95	
	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies or a service associated with the injection of botulinum toxin except those services to which item 18354 applies (Anaes.)	
18292	(See para TN.7.5 of explanatory notes to this Category) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45	
	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.)	
18294	Fee: \$181.50 Benefit: 75% = \$136.15 85% = \$154.30	
	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
18296	Fee: \$155.25 Benefit: 75% = \$116.45 85% = \$132.00	
10230	Assistance at the administration of an epidural blood patch (a service to which item 18233 applies) by another medical practitioner	
18297	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.)	
18298	Fee: \$181.50 Benefit: 75% = \$136.15 85% = \$154.30	
T8. SUF	RGICAL OPERATIONS 1. GENERAL	
	Group T8. Surgical Operations	
	Subgroup 1. General	
	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds	
30001	(See para TN.8.5 of explanatory notes to this Category) Derived Fee: 50% of the fee which would have applied had the procedure not been discontinued	
	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	
30003	Fee: \$37.45 Benefit: 75% = \$28.10 85% = \$31.85	
	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation	
	Fee: \$47.95 Benefit: 75% = \$36.00 85% = \$40.80	
30006		
30006	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.)	
30006		

18. SUF	URGICAL OPERATIONS 1. GENE		
	Fee: \$160.25	Benefit: 75% = \$120.20	
		n of, under general anaesthesia, involving not more that not carried out during the same operation (Anaes.) (A	
30017	Fee: \$336.20	Benefit: 75% = \$252.15 85% = \$285.80	
	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.)		
30020	Fee: \$654.85	Benefit: 75% = \$491.15	
	WOUND OF SOFT TISSUE, traumatic, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)		
30023	(See para TN.8.6 or Fee: \$336.20	f explanatory notes to this Category) Benefit: 75% = \$252.15 85% = \$285.80	
	WOUND OF SOFT TISSUE, debridement of extensively infected post-surgical incision or Fournier's Gangrene, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.)		
30024	Fee: \$336.20	Benefit: 75% = \$252.15 85% = \$285.80	
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes.) (See para TN.8.6 of explanatory notes to this Category) Fee: \$53.85 Benefit: 75% = \$40.40 85% = \$45.80		
30020	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes.)		
30029	(See para TN.8.6 of explanatory notes to this Category) Fee: \$92.80 Benefit: 75% = \$69.60 85% = \$78.90		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG superficial (Anaes.)		
30032	(See para TN.8.6 or Fee: \$85.05	f explanatory notes to this Category) Benefit: 75% = \$63.80 85% = \$72.30	
		CUTANEOUS TISSUE OR MUCOUS MEMBRANE closure at time of surgery, on face or neck, small (NC tissue (Anaes.)	
30035	(See para TN.8.6 or Fee: \$121.25	f explanatory notes to this Category) Benefit: 75% = \$90.95 85% = \$103.10	
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUN other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM I superficial, not being a service to which another item in Group T4 applies (Anaes.)		(MORE THAN 7 CM LONG),
30038	(See para TN.8.6 of explanatory notes to this Category) Fee: \$92.80 Benefit: 75% = \$69.60 85% = \$78.90		
30042		CUTANEOUS TISSUE OR MUCOUS MEMBRANE closure at time of surgery, other than on face or neck,	

T8. SUF	SURGICAL OPERATIONS 1. GENERA		
	LONG), involving deeper tissue, other than a service to which another item (Anaes.)	n in Group T4 applies	
	(See para TN.8.6 of explanatory notes to this Category) Fee: \$191.40 Benefit: 75% = \$143.55 85% = \$162.70		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, R other than wound closure at time of surgery, on face or neck, large (MORE superficial (Anaes.)		
30045	(See para TN.8.6 of explanatory notes to this Category) Fee: \$121.25 Benefit: 75% = \$90.95 85% = \$103.10		
	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.)		
30049	(See para TN.8.6 of explanatory notes to this Category) Fee: \$191.40 Benefit: 75% = \$143.55 85% = \$162.70		
	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, 1 apposition of each layer of tissue (Anaes.) (Assist.)	repair of, with accurate	
30052	Fee: \$261.90 Benefit: 75% = \$196.45 85% = \$222.65		
	WOUNDS, DRESSING OF, under general anaesthesia, with or without reservice associated with a service to which another item in this Group applies		
30055	Fee: \$76.25 Benefit: 75% = \$57.20 85% = \$64.85		
	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthe procedure (Anaes.)	esia, as an independent	
30058	Fee: \$148.85 Benefit: 75% = \$111.65 85% = \$126.55		
	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from corne independent procedure (Anaes.)	ea or sclera), as an	
30061 Fee: \$24.25 Benefit: 75% = \$18.20 85% = \$20.65			
	Etonogestrel subcutaneous implant, removal of, as an independent procedu	re (Anaes.)	
30062	Fee: \$62.65 Benefit: 75% = \$47.00 85% = \$53.30		
	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and of wound if performed, as an independent procedure (Anaes.)	exploration, including closure	
30064	Fee: \$113.30 Benefit: 75% = \$85.00 85% = \$96.35		
	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, r procedure (Anaes.) (Assist.)	removal of, as an independent	
30068	Fee: \$285.45 Benefit: 75% = \$214.10 85% = \$242.65		
	Diagnostic biopsy of skin, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)		
30071	(See para TN.8.7 of explanatory notes to this Category) Fee: \$53.85 Benefit: 75% = \$40.40 85% = \$45.80 Extended Medicare Safety Net Cap: \$43.10		
30072	Diagnostic biopsy of mucous membrane, as an independent procedure, if the	ne biopsy specimen is sent for	

T8. SUF	RGICAL OPERATIONS 1. GENERA	AL
	pathological examination (Anaes.)	
	(See para TN.8.7 of explanatory notes to this Category) Fee: \$53.85 Benefit: 75% = \$40.40 85% = \$45.80	
	DIAGNOSTIC BIOPSY OF LYMPH NODE, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure, if the biopsy specimen is sent for pathological examination (Anaes.)	3
30075	Fee: \$154.45 Benefit: 75% = \$115.85 85% = \$131.30	
	DIAGNOSTIC DRILL BIOPSY OF LYMPH NODE, DEEP TISSUE OR ORGAN, as an independent procedure, where the biopsy specimen is sent for pathological examination (Anaes.)	t
30078	(See para TN.8.7 of explanatory notes to this Category) Fee: \$50.00 Benefit: 75% = \$37.50 85% = \$42.50	
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using open approach, where the biopsy specimen is sent for pathological examination (Anaes.)	
30081	(See para TN.8.7 of explanatory notes to this Category) Fee: \$113.30 Benefit: 75% = \$85.00 85% = \$96.35	
	DIAGNOSTIC BIOPSY OF BONE MARROW by trephine using percutaneous approach where the biopsy is sent for pathological examination (Anaes.)	
30084	(See para TN.8.7 of explanatory notes to this Category) Fee: \$60.65 Benefit: 75% = \$45.50 85% = \$51.60	
	DIAGNOSTIC BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE, where the biopsy is sent for pathological examination (Anaes.)	
30087	(See para TN.8.7 of explanatory notes to this Category) Fee: \$30.35 Benefit: 75% = \$22.80 85% = \$25.80	
	DIAGNOSTIC BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion, whe the biopsy is sent for pathological examination (Anaes.)	ere
30090	(See para TN.8.7 of explanatory notes to this Category) Fee: \$132.55 Benefit: 75% = \$99.45 85% = \$112.70	
	DIAGNOSTIC NEEDLE BIOPSY OF VERTEBRA, where the biopsy is sent for pathological examination (Anaes.)	
30093	(See para TN.8.7 of explanatory notes to this Category) Fee: \$176.90 Benefit: 75% = \$132.70 85% = \$150.40	
	DIAGNOSTIC PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imagin techniques - but not including imaging, where the biopsy is sent for pathological examination (Anaes.)	
30094	(See para TN.8.7 of explanatory notes to this Category) Fee: \$195.35 Benefit: 75% = \$146.55 85% = \$166.05	
	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.)	r
30096	(See para TN.8.7 of explanatory notes to this Category) Fee: \$189.65 Benefit: 75% = \$142.25 85% = \$161.25	
30097	Personal performance of a Synacthen Stimulation Test, including associated consultation; by a medical practitioner with resuscitation training and access to facilities where life support procedures can be implemented, if:	1

T8. SUF	RGICAL OPERAT	IONS	1. GENERAL
	greater	cortisol at 0830-0930 hours on any day in the preceding mothan 100 nmol/L but less than 400 nmol/L; or ient who is acutely unwell and adrenal insufficiency is susp	
	(See para TN.8.13 Fee: \$100.20	9 of explanatory notes to this Category) Benefit: 75% = \$75.15 85% = \$85.20	
	SINUS, excision	of, involving superficial tissue only (Anaes.)	
30099	Fee: \$92.80	Benefit: 75% = \$69.60 85% = \$78.90	
	SINUS, excision	of, involving muscle and deep tissue (Anaes.)	
30103	Fee: \$189.65	Benefit: 75% = \$142.25 85% = \$161.25	
	PRE-AURICUL	AR SINUS, on a person 10 years of age or over. Excision	of, (Anaes.)
30104	Fee: \$130.90	Benefit: 75% = \$98.20 85% = \$111.30	
	PRE-AURICUL	AR SINUS, on a person under 10 years of age. Excision o	f, (Anaes.)
30105	Fee: \$170.10	Benefit: 75% = \$127.60 85% = \$144.60	
		R SMALL BURSA, excision of, other than a service associ his Group applies (Anaes.)	ated with a service to which
30107	Fee: \$226.80	Benefit: 75% = \$170.10 85% = \$192.80	
	BURSA (LARC (Assist.)	E), INCLUDING OLECRANON, CALCANEUM OR PA	TELLA, excision of (Anaes.)
30111	Fee: \$383.10	Benefit: 75% = \$287.35 85% = \$325.65	
	BURSA, SEMII	MEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Ass	sist.)
30114	Fee: \$383.10	Benefit: 75% = \$287.35	
	Lipectomy, wedge excision of abdominal apron that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30168, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:		
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and		
	(b) the abdominal apron interferes with the activities of daily living; and		
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy		
	(H) (Anaes.) (Assist.)		
30165	(See para TN.8.8 Fee: \$469.10	of explanatory notes to this Category) Benefit: 75% = \$351.85	
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct consequence of significant weight loss, not being a service associated with a service to which item 30165, 30171, 30172, 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:		
30168	(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		

T8. SUF	GICAL OPERATIONS	1. GENERAL	
	(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 pr lipectomy; and	ior to the	
	(d) the procedure involves 1 excision only		
	(H) (Anaes.) (Assist.)		
	(See para TN.8.8 of explanatory notes to this Category) Fee: \$469.10 Benefit: 75% = \$351.85		
	Lipectomy, wedge excision of redundant non abdominal skin and fat that is a direct co significant weight loss, not being a service associated with a service to which item 301 30176, 30177, 30179, 45530, 45564 or 45565 applies, if:		
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has f conventional (or non surgical) treatment; and	ailed 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	ior to the	
	(d) the procedure involves 2 excisions only		
	(H) (Anaes.) (Assist.)		
30171	(See para TN.8.8 of explanatory notes to this Category) Fee: \$713.35 Benefit: 75% = \$535.05		
	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 f conventional (or non surgical) treatment; and	ailed 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	ior to the	
	(d) the procedure involves 3 or more excisions		
	(H) (Anaes.) (Assist.)		
	(See para TN.8.8 of explanatory notes to this Category)		
30172	Fee: \$713.35 Benefit: 75% = \$535.05		
	Lipectomy, radical abdominoplasty (Pitanguy type or similar), with excision of skin artissue, repair of musculoaponeurotic layer and transposition of umbilicus, not being a swith a service to which item 30165, 30168, 30171, 30172, 30177, 30179, 45530, 4556 applies, if the patient has previously had a massive intra-abdominal or pelvic tumour standards.) (Assist.)	ervice associated 4 or 45565	
30176	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,016.45 Benefit: 75% = \$762.35		

T8. SUF	GICAL OPERATIONS 1. GENERAL		
	Lipectomy, excision of skin and subcutaneous tissue associated with redundant abdominal skin and fat that is a direct consequence of significant weight loss, in conjunction with a radical abdominoplasty (Pitanguy type or similar), with or without repair of musculoaponeurotic layer and transposition of umbilicus, not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30179, 45530, 45564 or 45565 applies, if:		
	(a) there is intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and		
	(b) the redundant skin and fat interferes with the activities of daily living; and		
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy		
	(H) (Anaes.) (Assist.)		
30177	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,016.45 Benefit: 75% = \$762.35		
	Circumferential lipectomy, as an independent procedure, to correct circumferential excess of redundant skin and fat that is a direct consequence of significant weight loss, with or without a radical abdominoplasty (Pitanguy type or similar), not being a service associated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177, 45530, 45564 or 45565 applies, if:		
	(a) the circumferential excess of redundant skin and fat is complicated by intertrigo or another skin condition that risks loss of skin integrity and has failed 3 months of conventional (or non surgical) treatment; and		
	(b) the circumferential excess of redundant skin and fat interferes with the activities of daily living; and		
	(c) the weight has been stable for at least 6 months following significant weight loss prior to the lipectomy		
	(H) (Anaes.) (Assist.)		
30179	(See para TN.8.8 of explanatory notes to this Category) Fee: \$1,251.05 Benefit: 75% = \$938.30		
	AXILLARY HYPERHIDROSIS, partial excision for (Anaes.)		
30180	Fee: \$140.80 Benefit: 75% = \$105.60 85% = \$119.70		
	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.)		
30183	Fee: \$254.20 Benefit: 75% = \$190.65 85% = \$216.10		
	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) Fee: \$264.95 Benefit: 75% = \$198.75 85% = \$225.25		
	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) Fee: \$151.90 Benefit: 75% = \$113.95		

T8. SUR	GICAL OPERATIONS 1. GENERA		
	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	Fee: \$410.15 Benefit: 75% = \$307.65 85% = \$348.65		
	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	Fee: \$65.45 Benefit: 75% = \$49.10 85% = \$55.65		
	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)		
30192	Fee: \$40.80 Benefit: 75% = \$30.60 85% = \$34.70 Malignant neoplasm of skin or mucous membrane that has been:		
	Wanghait heopiash of skill of flucous memorane that has been.		
	(a) proven by histopathology; or		
	(b) confirmed by the opinion of a specialist in the specialty of dermatology or plastic surgery 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.)		
Amend 30196	(See para TN.8.10 of explanatory notes to this Category) Fee: \$130.20 Benefit: 75% = \$97.65 85% = \$110.70		
	Malignant neoplasm of skin or mucous membrane proven by histopathology or confirmed by the opinio of a specialist in the specialty of dermatology or plastic surgery—removal of, by liquid nitrogen cryotherapy using repeat freeze thaw cycles		
Amend 30202	(See para TN.8.10 of explanatory notes to this Category) Fee: \$49.85 Benefit: 75% = \$37.40 85% = \$42.40		
	Skin lesions, multiple injections with glucocorticoid preparations (Anaes.)		
30207	Fee: \$46.00 Benefit: 75% = \$34.50 85% = \$39.10		
	Keloid and other skin lesions, extensive, multiple injections of glucocorticoid preparations, if undertake in the operating theatre of a hospital on a patient less than 16 years of age (Anaes.)		
30210	Fee: \$168.05 Benefit: 75% = \$126.05		
	HAEMATOMA, aspiration of (Anaes.)		
30216	Fee: \$28.20 Benefit: 75% = \$21.15 85% = \$24.00		
30210	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to		
	a hospital - INCISION WITH DRAINAGE OF (excluding aftercare)		
30219	(See para TN.8.4 of explanatory notes to this Category) Fee: \$28.20 Benefit: 75% = \$21.15 85% = \$24.00		

T8. SUR	GICAL OPERAT	IONS 1. GENERAL
		ATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, ion to a hospital, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.)
30223	(See para TN.8.4 c Fee: \$168.05	f explanatory notes to this Category) Benefit: 75% = \$126.05
	PERCUTANEO not including im	US DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but aging (Anaes.)
30224	Fee: \$245.00	Benefit: 75% = \$183.75 85% = \$208.25
	ABSCESS DRA imaging (Anaes.	INAGE TUBE, exchange of using interventional imaging techniques - but not including)
30225	Fee: \$276.05	Benefit: 75% = \$207.05 85% = \$234.65
	MUSCLE, excis	ion of (LIMITED), or fasciotomy (Anaes.)
30226	Fee: \$154.45	Benefit: 75% = \$115.85 85% = \$131.30
	MUSCLE, excis	ion of (EXTENSIVE) (Anaes.) (Assist.)
30229	Fee: \$281.45	Benefit: 75% = \$211.10 85% = \$239.25
	MUSCLE, RUP	TURED, repair of (limited), not associated with external wound (Anaes.)
30232	Fee: \$230.60	Benefit: 75% = \$172.95 85% = \$196.05
	MUSCLE, RUP	TURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.)
30235	Fee: \$304.95	Benefit: 75% = \$228.75 85% = \$259.25
		repair of, FOR HERNIATED MUSCLE (Anaes.)
30238	Fee: \$154.45	Benefit: 75% = \$115.85 85% = \$131.30
	BONE TUMOU applies (Anaes.)	R, INNOCENT, excision of, not being a service to which another item in this Group (Assist.)
30241	Fee: \$367.50	Benefit: 75% = \$275.65 85% = \$312.40
	STYLOID PRO	CESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.)
30244	Fee: \$367.50	Benefit: 75% = \$275.65
	PAROTID DUC	T, repair of, using micro-surgical techniques (Anaes.) (Assist.)
30246	Fee: \$711.35	Benefit: 75% = \$533.55
	PAROTID GLAND, total extirpation of (Anaes.) (Assist.)	
30247	Fee: \$762.45	Benefit: 75% = \$571.85
		ND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.)
30250	Fee: \$1,290.15 Benefit: 75% = \$967.65	
	· ·	AROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.)
30251	Fee: \$1,981.80	Benefit: 75% = \$1486.35 85% = \$1897.10
		ND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.)
30253	Fee: \$860.10	Benefit: 75% = \$645.10
30253		ND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anae Benefit: 75% = \$645.10

T8. SUF	RGICAL OPERATION	ONS 1. GENERAI
	SUBMANDIBUL	AR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.)
30255	Fee: \$1,145.35	Benefit: 75% = \$859.05
	SUBMANDIBUL	AR GLAND, extirpation of (Anaes.) (Assist.)
30256	Fee: \$459.35	Benefit: 75% = \$344.55
	SUBLINGUAL G	LAND, extirpation of (Anaes.)
30259	Fee: \$204.75	Benefit: 75% = \$153.60 85% = \$174.05
	SALIVARY GLA	ND, DILATATION OR DIATHERMY of duct (Anaes.)
30262	Fee: \$60.65	Benefit: 75% = \$45.50 85% = \$51.60
	Salivary gland, reprocedures. (Anae	moval of calculus from duct or meatotomy or marsupialisation, 1 or more such es.)
30266	Fee: \$154.45	Benefit: 75% = \$115.85 85% = \$131.30
	SALIVARY GLA	ND, repair of CUTANEOUS FISTULA OF (Anaes.)
30269	Fee: \$154.45	Benefit: 75% = \$115.85 85% = \$131.30
	TONGUE, partial	excision of (Anaes.) (Assist.)
30272	Fee: \$304.95	Benefit: 75% = \$228.75 85% = \$259.25
		SION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE ODES OF NECK (commandotype operation) (Anaes.) (Assist.)
30275	Fee: \$1,817.80	Benefit: 75% = \$1363.35
	TONGUE TIE, re	pair of, not being a service to which another item in this Group applies (Anaes.)
30278	Fee: \$47.95	Benefit: 75% = \$36.00 85% = \$40.80
		ANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person over, under general anaesthesia (Anaes.)
30281	Fee: \$123.20	Benefit: 75% = \$92.40 85% = \$104.75
	RANULA OR MU	JCOUS CYST OF MOUTH, removal of (Anaes.)
30283	Fee: \$211.10	Benefit: 75% = \$158.35 85% = \$179.45
	BRANCHIAL CY	YST, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.)
30286	Fee: \$410.25	Benefit: 75% = \$307.70 85% = \$348.75
	BRANCHIAL CY	ST, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)
30287	Fee: \$533.40	Benefit: 75% = \$400.05 85% = \$453.40
	BRANCHIAL FIS	STULA, on a person 10 years of age or over. Removal of, (Anaes.) (Assist.)
30289	Fee: \$517.95	Benefit: 75% = \$388.50
		OPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or pair (Anaes.) (Assist.)
30293	Fee: \$459.35	Benefit: 75% = \$344.55 85% = \$390.45
30294	CERVICAL OES	OPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic

T8. SUF	RGICAL OPERATIONS 1. GENERA
	reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.)
	Fee: \$1,817.80 Benefit: 75% = \$1363.35
	THYROIDECTOMY, total (Anaes.) (Assist.)
30296	(See para TN.8.137 of explanatory notes to this Category) Fee: \$1,055.70 Benefit: 75% = \$791.80
	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.)
30297	(See para TN.8.138 of explanatory notes to this Category) Fee: \$1,055.70 Benefit: 75% = \$791.80
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30300, 30302 or 30303 applies (Anaes.) (Assist.)
30299	(See para TN.8.12 of explanatory notes to this Category) Fee: \$657.35 Benefit: 75% = \$493.05
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using preoperative lymphoscintigraphy and lymphotropic dye injection, not being a service associated with a service to which item 30299, 30302 or 30303 applies (Anaes.) (Assist.)
30300	(See para TN.8.12 of explanatory notes to this Category) Fee: \$788.80 Benefit: 75% = \$591.60
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30303 applies (Anaes.) (Assist.)
30302	(See para TN.8.12 of explanatory notes to this Category) Fee: \$525.85 Benefit: 75% = \$394.40
	SENTINEL LYMPH NODE BIOPSY OR BIOPSIES for breast cancer, involving dissection in a level II/III axilla, using lymphotropic dye injection, not being a service associated with a service to which item 30299, 30300 or 30302 applies (Anaes.) (Assist.)
30303	(See para TN.8.12 of explanatory notes to this Category) Fee: \$630.95 Benefit: 75% = \$473.25
	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.)
30306	(See para TN.8.137, TN.8.138 of explanatory notes to this Category) Fee: \$823.60 Benefit: 75% = \$617.70
	Partial or subtotal thyroidectomy (Anaes.) (Assist.)
30310	(See para TN.8.137 of explanatory notes to this Category) Fee: \$823.60 Benefit: 75% = \$617.70
	THYROGLOSSAL CYST or FISTULA or both, on a person 10 years of age or over. Radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.)
30314	Fee: \$471.65 Benefit: 75% = \$353.75
	Minimally invasive parathyroidectomy. Removal of 1 or more parathyroid adenoma through a small cervical incision for an image localised adenoma, including thymectomy.
30315	

T8. SUF	RGICAL OPERATION	DNS 1.	GENERAL
	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.)
	Fee: \$1,175.50	Benefit: 75% = \$881.65	
		ctomy. Cervical re-exploration for persistent or recurrent hyperparathyroiomy 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	Fee: \$1,407.55	Benefit: 75% = \$1055.70	
		ectomy, exploration and removal of 1 or more adenoma or hyperplastic glancluding 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	Fee: \$1,175.50	Benefit: 75% = \$881.65	
	Removal of a med	iastinal parathyroid adenoma via sternotomy or mediastinal thorascopic aj	pproach.
	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	Fee: \$1,407.55	Benefit: 75% = \$1055.70	
	Excision of phaeo (Anaes.) (Assist.)	chromocytoma or extraadrenal paraganglioma via endoscopic or open app	roach.
30323	Fee: \$1,407.55	Benefit: 75% = \$1055.70	
	Excision of an adr	enocortical tumour or hyperplasia via endoscopic or open approach. (Anac	es.) (Assist.)
30324	Fee: \$1,407.55	Benefit: 75% = \$1055.70	
	THYROGLOSSA	L CYST or FISTULA or both, radical removal of, including thyroglossal one, on a person under 10 years of age (Anaes.) (Assist.)	duct and
30326	Fee: \$613.15	Benefit: 75% = \$459.90	
	LYMPH NODES	of GROIN, limited excision of (Anaes.)	
30329	Fee: \$254.65	Benefit: 75% = \$191.00 85% = \$216.50	
	<u> </u>	of GROIN, radical excision of (Anaes.) (Assist.)	
30330	Fee: \$741.20	Benefit: 75% = \$555.90	
		of AXILLA, limited excision of (sampling) (Anaes.) (Assist.)	
30332	Fee: \$357.60	Benefit: 75% = \$268.20	
3332		of AXILLA, complete excision of, to level I (Anaes.) (Assist.)	
		f explanatory notes to this Category)	
30335	Fee: \$893.90	Benefit: 75% = \$670.45	

		1. GENERAL
LYMPH NODES of	of AXILLA, complete excision of, to level II or level III (Anaes.)	(Assist.)
(See para TN.8.13 of Fee: \$1,072.75	explanatory notes to this Category) Benefit: 75% = \$804.60	
		-abdominal procedure
Fee: \$498.35	Benefit: 75% = \$373.80	
Gastrotomy, on a p diverticulum, Sutur	erson 10 years of age or over. Reduction of intussusception, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of perforated peptic ulcer, Simple repair of ruptured viscus, Rene of ruptur	noval of Meckel's
(See para TN.8.14 of Fee: \$537.55	explanatory notes to this Category) Benefit: 75% = \$403.20	
Fee: \$537.55	Benefit: 75% = \$403.20	
where the time take	en to divide the adhesions is between 45 minutes and 2 hours, on	
Fee: \$540.10	Benefit: 75% = \$405.10	
		ater than 2 hours)
Fee: \$957.15	Benefit: 75% = \$717.90	
		n and resection of
Fee: \$1,347.70	Benefit: 75% = \$1010.80	
		biopsies, lymph
Fee: \$1,133.75	Benefit: 75% = \$850.35	
		nere no other
Fee: \$580.90	Benefit: 75% = \$435.70	
		uding pelvic viscera),
Fee: \$654.85	Benefit: 75% = \$491.15	
LAPAROTOMY fo	or trauma involving 3 or more organs (Anaes.) (Assist.)	
Fee: \$1,647.45	Benefit: 75% = \$1235.60	
LAPAROSCOPY,		copic procedure, on a
	explanatory notes to this Category)	
	(See para TN.8.13 of Fee: \$1,072.75 LAPAROTOMY (is performed (Anaes Fee: \$498.35) Caecostomy, Enter Gastrotomy, on a p diverticulum, Sutur Pyloroplasty (adult (See para TN.8.14 of Fee: \$537.55 LAPAROTOMY II intraabdominal pro Fee: \$537.55 LAPAROTOMY II where the time take age or over (Anaes Fee: \$540.10 LAPAROTOMY With or without inserties \$957.15 ENTEROCUTANI bowel (Anaes.) (As Fee: \$1,347.70 LAPAROTOMY Fee: \$1,347.70 LAPAROTOMY For the procedure is perfor Fee: \$580.90 LAPAROTOMY II not being a service Fee: \$654.85 LAPAROTOMY II not being a service Fee: \$1,647.45 LAPAROSCOPY,	(See para TN.8.13 of explanatory notes to this Category) Fee: \$1.072.75 Benefit: 75% = \$804.60 LAPAROTOMY (exploratory), including associated biopsies, where no other intrais performed (Anaes.) (Assist.) Fee: \$498.35 Benefit: 75% = \$373.80 Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrotomy, on a person 10 years of age or over. Reduction of intussusception, Rer diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Re Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) (See para TN.8.14 of explanatory notes to this Category) Fee: \$537.55 Benefit: 75% = \$403.20 LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (who intraabdominal procedure is performed) on a person 10 years of age or over (Anaes.) Fee: \$537.55 Benefit: 75% = \$403.20 LAPAROTOMY involving division of adhesions in conjunction with another intract where the time taken to divide the adhesions is between 45 minutes and 2 hours, on age or over (Anaes.) (Assist.) Fee: \$40.10 Benefit: 75% = \$405.10 LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greated with or without insertion of long intestinal tube (Anaes.) (Assist.) Fee: \$957.15 Benefit: 75% = \$717.90 ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection bowel (Anaes.) (Assist.) Fee: \$1,347.70 Benefit: 75% = \$1010.80 LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver node biopsies and oophoropexy (Anaes.) (Assist.) Fee: \$1,133.75 Benefit: 75% = \$850.35 LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where the procedure is performed (Anaes.) (Assist.) Fee: \$858.90 Benefit: 75% = \$435.70 LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where the performed (Anaes.) (Assist.) Fee: \$654.85 Benefit: 75% = \$435.70 LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$654.85 Benefit: 75% = \$491.15

18. SUF	RGICAL OPERAT				
	Fee: \$226.80	Benefit: 75% = \$170.10			
	LAPAROSCOP	Y with biopsy (Anaes.) (Assist.)			
30391	Fee: \$293.25	Benefit: 75% = \$219.95			
		DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without an independent procedure (Anaes.) (Assist.)			
30392	Fee: \$695.60	Benefit: 75% = \$521.70			
		IC DIVISION OF ADHESIONS in association with another intra-abdominal procedure aken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.)			
30393	Fee: \$540.10	Benefit: 75% = \$405.10			
		for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.)			
30394	Fee: \$508.25	Benefit: 75% = \$381.20			
	removal of foreig	If for gross intra peritoneal sepsis requiring debridement of fibrin, with or without gn material or enteric contents, with lavage of the entire peritoneal cavity via a major on, with or without closure of abdomen and with or without mesh or zipper insertion ()			
30396	(See para TN.8.16 Fee: \$1,048.30	of explanatory notes to this Category) Benefit: 75% = \$786.25			
		Y, via wound previously made and left open or closed with zipper, involving change of ss, and with or without drainage of loculated collections (Anaes.)			
30397	Fee: \$239.60	Benefit: 75% = \$179.70			
		Y, final closure of wound made at previous operation, after removal of dressings or al of mesh or zipper if previously inserted (Anaes.) (Assist.)			
30399	Fee: \$329.55	Benefit: 75% = \$247.20			
		WITH INSERTION OF PORTACATH for administration of cytotoxic therapy nent of reservoir (Anaes.) (Assist.)			
30400	Fee: \$652.25	Benefit: 75% = \$489.20			
	RETROPERITO	NEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.)			
30402	Fee: \$479.15	Benefit: 75% = \$359.40			
		CISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of with or			
30403	Fee: \$537.55	Benefit: 75% = \$403.20			
	VENTRAL OR	INCISIONAL HERNIA, (excluding recurrent inguinal or femoral hernia), repair of, transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.)			
30405	Fee: \$943.55	Benefit: 75% = \$707.70			
		PARACENTESIS ABDOMINIS (Anaes.)			
30406	Fee: \$53.85	Benefit: 75% = \$40.40 85% = \$45.80			
20700	<u> </u>	ENOUS shunt, insertion of (Anaes.) (Assist.)			
30408		, , , , , , , , , , , , , , , , , , , ,			

T8. SUF	RGICAL OPERAT	ONS 1. GENERAL		
	Fee: \$404.35	Benefit: 75% = \$303.30		
	LIVER BIOPSY	, percutaneous (Anaes.)		
30409	Fee: \$179.90	Benefit: 75% = \$134.95 85% = \$152.95		
	LIVER BIOPSY procedure (Anae	by wedge excision when performed in conjunction with another intraabdominal s.)		
30411	Fee: \$91.55	Benefit: 75% = \$68.70		
	LIVER BIOPSY (Anaes.)	by core needle, when performed in conjunction with another intra-abdominal procedure		
30412	Fee: \$54.00	Benefit: 75% = \$40.50 85% = \$45.90		
	LIVER, subsegm	ental resection of, (local excision), other than for trauma (Anaes.) (Assist.)		
30414	Fee: \$711.35	Benefit: 75% = \$533.55		
	LIVER, segment	al resection of, other than for trauma (Anaes.) (Assist.)		
30415	Fee: \$1,422.55	Benefit: 75% = \$1066.95		
	LIVER CYST, la diameter (Anaes	paroscopic marsupialisation of, where the size of the cyst is greater than 5cm in (Assist.)		
30416	Fee: \$772.35	Benefit: 75% = \$579.30		
	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.)			
30417	Fee: \$1,158.45	Benefit: 75% = \$868.85		
	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.)			
30418	Fee: \$1,647.45	Benefit: 75% = \$1235.60		
		RS, destruction of, by hepatic cryotherapy, not being a service associated with a service 950 or 50952 applies (Anaes.) (Assist.)		
30419	Fee: \$842.60	Benefit: 75% = \$631.95 85% = \$757.90		
	LIVER, TRI-SE (Assist.)	GMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.)		
30421	Fee: \$2,058.95	Benefit: 75% = \$1544.25		
	LIVER, repair of	superficial laceration of, for trauma (Anaes.) (Assist.)		
30422	Fee: \$696.45	Benefit: 75% = \$522.35		
	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.)			
30425	Fee: \$1,347.70	Benefit: 75% = \$1010.80		
	LIVER, segment	al resection of, for trauma (Anaes.) (Assist.)		
30427	Fee: \$1,609.75	Benefit: 75% = \$1207.35		
	LIVER, lobectomy of, for trauma (Anaes.) (Assist.)			
30428	Fee: \$1,722.15	Benefit: 75% = \$1291.65 85% = \$1637.45		

T8. SUF	RGICAL OPERAT	ONS 1. GENERAL
	LIVER, extende	lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.)
30430	Fee: \$2,395.85	Benefit: 75% = \$1796.90 85% = \$2311.15
	LIVER ABSCE	S, open abdominal drainage of (Anaes.) (Assist.)
30431	Fee: \$537.55	Benefit: 75% = \$403.20 85% = \$456.95
	LIVER ABSCE	S (multiple), open abdominal drainage of (Anaes.) (Assist.)
30433	Fee: \$748.70	Benefit: 75% = \$561.55
		Γ OF LIVER, peritoneum or viscus, complete removal of contents of, with or without radicles (Anaes.) (Assist.)
30434	Fee: \$606.50	Benefit: 75% = \$454.90
		Γ OF LIVER, peritoneum or viscus, complete removal of contents of, with or without radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.)
30436	Fee: \$673.85	Benefit: 75% = \$505.40
	HYDATID CYS (Anaes.) (Assist	T OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall)
30437	Fee: \$838.70	Benefit: 75% = \$629.05
	HYDATID CYS	Γ OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.)
30438	Fee: \$1,186.80	Benefit: 75% = \$890.10 85% = \$1102.10
	OPERATIVE U	HOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA TRASOUND of the biliary tract (including 1 or more examinations performed during Anaes.) (Assist.)
30439	Fee: \$191.40	Benefit: 75% = \$143.55
	interventional in	RAM, percutaneous transhepatic, and insertion of biliary drainage tube, using aging techniques - but not including imaging, not being a service associated with a item 30451 applies (Anaes.) (Assist.)
30440	Fee: \$542.80	Benefit: 75% = \$407.10 85% = \$461.40
	INTRA OPERA	TIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.)
30441	Fee: \$140.55	Benefit: 75% = \$105.45
	CHOLEDOCHO	SCOPY in conjunction with another procedure (Anaes.)
30442	Fee: \$191.40	Benefit: 75% = \$143.55
	CHOLECYSTE	CTOMY (Anaes.) (Assist.)
30443	Fee: \$762.45	Benefit: 75% = \$571.85
	LAPAROSCOP	C CHOLECYSTECTOMY (Anaes.) (Assist.)
30445	Fee: \$762.45	Benefit: 75% = \$571.85
	LAPAROSCOP (Assist.)	C CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.)
30446	Fee: \$762.45	Benefit: 75% = \$571.85

T8. SUF	RGICAL OPERATION	ONS 1. GENER	RAL	
	LAPAROSCOPIC duct (Anaes.) (Ass	C CHOLECYSTECTOMY, involving removal of common duct calculi via the cystsist.)	ic	
30448	Fee: \$1,003.30	Benefit: 75% = \$752.50		
	LAPAROSCOPIC choledochotomy (C CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic Anaes.) (Assist.)		
30449	Fee: \$1,115.65	Benefit: 75% = \$836.75		
		or renal tract, extraction of, using interventional imaging techniques - other than a with a service to which items 36627 or 36645 applies (Anaes.) (Assist.)	a	
30450	Fee: \$540.80	Benefit: 75% = \$405.60 85% = \$459.70		
		NAGE TUBE, exchange of, using interventional imaging techniques - but not include a service associated with a service to which item 30440 applies (Anaes.) (Assist.)		
30451	Fee: \$276.05	Benefit: 75% = \$207.05 85% = \$234.65		
	CHOLEDOCHOS (Anaes.) (Assist.)	SCOPY with balloon dilation of a stricture or passage of stent or extraction of calcu	ıli	
30452	Fee: \$389.30	Benefit: 75% = \$292.00		
	CHOLEDOCHOT (Assist.)	TOMY (with or without cholecystectomy), with or without removal of calculi (Ana	es.)	
30454	Fee: \$889.45	Benefit: 75% = \$667.10		
		FOMY (with or without cholecystectomy), with removal of calculi including biliary osis (Anaes.) (Assist.)	y	
30455	Fee: \$1,045.70	Benefit: 75% = \$784.30		
	CHOLEDOCHOT (Assist.)	TOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.)		
30457	Fee: \$1,422.55	Benefit: 75% = \$1066.95 85% = \$1337.85		
	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.)			
30458	Fee: \$1,045.70	Benefit: 75% = \$784.30		
	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.)			
30460	Fee: \$889.45	Benefit: 75% = \$667.10		
	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (Anaes.) (Assist.)			
30461	Fee: \$1,524.60	Benefit: 75% = \$1143.45		
	RADICAL RESE	CTION of common hepatic duct and right and left hepatic ducts, with 2 duct es.) (Assist.)		
30463	Fee: \$1,871.90	Benefit: 75% = \$1403.95		

T8. SUF	RGICAL OPERATION	ONS	1. GENERAL	
		CTION of common hepatic duct and right and left hepatic ducts, resection of segment or major portion of segment of liver (Anaes.		
30464	Fee: \$2,246.30	Benefit: 75% = \$1684.75		
	INTRAHEPATIC system (Anaes.) (A	biliary bypass of left hepatic ductal system by Roux-en-Y loop t Assist.)	o peripheral ductal	
30466	Fee: \$1,295.30	Benefit: 75% = \$971.50		
	INTRAHEPATIC system (Anaes.) (A	BYPASS of right hepatic ductal system by Roux-en-Y loop to p Assist.)	eripheral ductal	
30467	Fee: \$1,602.25	Benefit: 75% = \$1201.70		
	BILIARY STRIC	TURE, repair of, after 1 or more operations on the biliary tree (A	naes.) (Assist.)	
30469	Fee: \$1,774.70	Benefit: 75% = \$1331.05 85% = \$1690.00		
		DMMON BILE DUCT, repair of, as the primary procedure subsect fible duct or ducts (Anaes.) (Assist.)	quent to partial or	
30472	Fee: \$958.35	Benefit: 75% = \$718.80 85% = \$873.65		
	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 Fee: \$182.65	f explanatory notes to this Category) Benefit: 75% = \$137.00 85% = \$155.30		
		tion of stricture of upper gastrointestinal tract (including the use of the clinically indicated) (Anaes.)	of imaging	
30475	(See para TN.8.17, Fee: \$359.85	ΓN.8.133 of explanatory notes to this Category) Benefit: 75% = \$269.90 85% = \$305.90		
	Oesophagoscopy (other than a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy, panendoscopy or push enteroscopy, one or more such procedures, if:			
	(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			
30478	(b) the procedures	are for the treatment of one or more of the following:		

T8. SURG	GICAL OPERATIONS 1. G	ENERAL
	(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) Fee: \$253.25 Benefit: 75% = \$189.95 85% = \$215.30	
	Endoscopy with laser therapy, for the treatment of one or more of the following:	
	(a) neoplasia;	
	(b) benign vascular lesions;	
	(c) strictures of the gastrointestinal tract;	
	(d) tumorous overgrowth through or over oesophageal stents;	
	(e) peptic ulcers;	
	(f) angiodysplasia;	
	(g) gastric antral vascular ectasia;	
	(h) post-polypectomy bleeding;	
	other than a service associated with a service to which item 30473 or 30478 applies (Anaes.)	
30479	(See para TN.8.17 of explanatory notes to this Category) Fee: \$490.95 Benefit: 75% = \$368.25 85% = \$417.35	
	PERCUTANEOUS GASTROSTOMY (initial procedure):	
	(a) including any associated imaging services; and	
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes.)	
30481	(See para TN.8.17 of explanatory notes to this Category) Fee: \$368.15 Benefit: 75% = \$276.15 85% = \$312.95	

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	PERCUTANEOUS GASTROSTOMY (repeat procedure):	
	(a) including any associated imaging services; and	
	(b) excluding the insertion of a device for the purpose of facilitating weight loss (Anaes	.)
30482	Fee: \$261.75 Benefit: 75% = \$196.35 85% = \$222.50	
	GASTROSTOMY BUTTON, CAECOSTOMY ANTEGRADE ENEMA DEVICE (CF STOMAL INDWELLING DEVICE:	HAIT etc.) or
	(a) non-endoscopic insertion of; or	
	(b) non-endoscopic replacement of;	
	on a person 10 years of age or over, excluding the insertion of a device for the purpose weight loss (Anaes.)	of facilitating
30483	Fee: \$182.60 Benefit: 75% = \$136.95 85% = \$155.25	
	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.)	
30484	(See para TN.8.17 of explanatory notes to this Category) Fee: \$376.30 Benefit: 75% = \$282.25 85% = \$319.90	
	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from comme (Anaes.)	on bile duct
30485	(See para TN.8.17 of explanatory notes to this Category) Fee: \$580.90 Benefit: 75% = \$435.70 85% = \$496.20	
	SMALL BOWEL INTUBATION as an independent procedure (Anaes.)	
30488	Fee: \$92.80 Benefit: 75% = \$69.60 85% = \$78.90	
	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Ana	aes.)
30490	(See para TN.8.17 of explanatory notes to this Category) Fee: \$542.80 Benefit: 75% = \$407.10 85% = \$461.40	
	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (A	naes.)
30491	(See para TN.8.17 of explanatory notes to this Category) Fee: \$572.70 Benefit: 75% = \$429.55 85% = \$488.00	
	BILE DUCT, PERCUTANEOUS STENTING OF (including dilatation when performe interventional imaging techniques - but not including imaging (Anaes.)	d), using
30492	Fee: \$811.90 Benefit: 75% = \$608.95	
	ENDOSCOPIC BILIARY DILATATION (Anaes.)	
30494	(See para TN.8.17 of explanatory notes to this Category) Fee: \$433.65 Benefit: 75% = \$325.25	
	PERCUTANEOUS BILIARY DILATATION for biliary stricture, using interventional	imaging
	techniques - but not including imaging (Anaes.)	
30495	Fee: \$811.90 Benefit: 75% = \$608.95	
_	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy	(Anaes.) (Assist.)
30496	Fee: \$606.50 Benefit: 75% = \$454.90 85% = \$521.80	
50470	Denem. 7370 — \$\phi +30 0370 = \phi 321.00	

T8. SUF	GICAL OPERATION	IS 1. GENEF	RAL
	VAGOTOMY and A	ANTRECTOMY (Anaes.) (Assist.)	
30497	Fee: \$723.20	Benefit: 75% = \$542.40	
	VAGOTOMY, high	ly selective (Anaes.) (Assist.)	
30499	Fee: \$860.10	Benefit: 75% = \$645.10	
	VAGOTOMY, high	ly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.)	
30500	Fee: \$921.00	Benefit: 75% = \$690.75 85% = \$836.30	
	VAGOTOMY, high	ly selective, with dilatation of pylorus (Anaes.) (Assist.)	
30502	Fee: \$1,016.45	Benefit: 75% = \$762.35	
	VAGOTOMY or Al ulcer (Anaes.) (Assis	NTRECTOMY, or both, for peptic ulcer following previous operation for peptic st.)	
30503	Fee: \$1,138.25	Benefit: 75% = \$853.70 85% = \$1053.55	
	BLEEDING PEPTION (Assist.)	C ULCER, control of, involving suture of bleeding point or wedge excision (Ana	es.)
30505	Fee: \$569.10	Benefit: 75% = \$426.85	
		C ULCER, control of, involving suture of bleeding point or wedge excision, and oplasty or gastroenterostomy (Anaes.) (Assist.)	
30506	Fee: \$995.90	Benefit: 75% = \$746.95	
		C ULCER, control of, involving suture of bleeding point or wedge excision, and otomy (Anaes.) (Assist.)	
30508	Fee: \$1,048.30	Benefit: 75% = \$786.25	
	BLEEDING PEPTION (Anaes.) (Assist.)	C ULCER, control of, involving gastric resection (other than wedge resection)	
30509	Fee: \$1,048.30	Benefit: 75% = \$786.25 85% = \$963.60	
		including gastroduodenostomy) or enterocolostomy or enteroenterostomy, not be ny of items 31569 to 31581 apply (Anaes.) (Assist.)	eing
30515	Fee: \$726.35	Benefit: 75% = \$544.80	
	GASTROENTEROS (Anaes.) (Assist.)	STOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction o	of
30517	Fee: \$951.00	Benefit: 75% = \$713.25	
	Partial gastrectomy, apply (Anaes.) (Assi	not being a service associated with a service to which any of items 31569 to 315 st.)	81
30518	Fee: \$1,018.35	Benefit: 75% = \$763.80	
	GASTRIC TUMOU (Anaes.) (Assist.)	R, removal of, by local excision, not being a service to which item 30518 applies	S
30520	Fee: \$696.45	Benefit: 75% = \$522.35	
	GASTRECTOMY,	ΓΟΤΑL, for benign disease (Anaes.) (Assist.)	
30521	Fee: \$1,490.00	Benefit: 75% = \$1117.50	

T8. SUF	RGICAL OPERATIONS 1. GENERA
	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.)
30523	(See para TN.8.18 of explanatory notes to this Category) Fee: \$1,557.25 Benefit: 75% = \$1167.95
	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.)
30524	Fee: \$1,714.60 Benefit: 75% = \$1285.95
	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.
30526	Fee: \$2,223.70 Benefit: 75% = \$1667.80
	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.)
30527	(See para TN.8.19 of explanatory notes to this Category) Fee: \$898.55 Benefit: 75% = \$673.95
	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagu (Anaes.) (Assist.)
30529	(See para TN.8.19 of explanatory notes to this Category) Fee: \$1,347.70 Benefit: 75% = \$1010.80
	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.)
30530	(See para TN.8.19 of explanatory notes to this Category) Fee: \$808.70 Benefit: 75% = \$606.55
	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.)
30532	(See para TN.8.19 of explanatory notes to this Category) Fee: \$928.55 Benefit: 75% = \$696.45
	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operatio (Anaes.) (Assist.)
30533	(See para TN.8.19 of explanatory notes to this Category) Fee: \$1,104.45 Benefit: 75% = \$828.35
	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.)
30535	Fee: \$1,749.65 Benefit: 75% = \$1312.25
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.)
30536	Fee: \$1,774.70 Benefit: 75% = \$1331.05
	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.)
30538	Fee: \$1,228.00 Benefit: 75% = \$921.00
30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and

T8. SUF	RGICAL OPERATION	ONS	1. GENERAL
	anastomosis in the	e neck or chest - conjoint surgery, co-surgeon (Assist.)	
	Fee: \$898.55	Benefit: 75% = \$673.95	
		OMY, by trans-hiatal oesophagectomy (cervical and abdominal posterior or anterior mediastinal placement - 1 surgeon (Anaes	
30541	Fee: \$1,564.95	Benefit: 75% = \$1173.75	
	anastomosis) with	OMY, by trans-hiatal oesophagectomy (cervical and abdomina a posterior or anterior mediastinal placement - conjoint surgery, re) (Anaes.) (Assist.)	
30542	Fee: \$1,063.30	Benefit: 75% = \$797.50	
		OMY, by trans-hiatal oesophagectomy (cervical and abdomina posterior or anterior mediastinal placement - conjoint surgery,	
30544	Fee: \$778.80	Benefit: 75% = \$584.10	
		OMY with colon or jejunal anastomosis, (abdominal and thoracosis) - 1 surgeon (Anaes.) (Assist.)	cic mobilisation with
30545	Fee: \$1,894.50	Benefit: 75% = \$1420.90	
		OMY with colon or jejunal anastomosis, (abdominal and thoracisis) - conjoint surgery, principal surgeon (including aftercare)	
30547	Fee: \$1,302.80	Benefit: 75% = \$977.10 85% = \$1218.10	
		OMY with colon or jejunal anastomosis, (abdominal and thoracisis) - conjoint surgery, co-surgeon (Assist.)	cic mobilisation with
30548	Fee: \$973.30	Benefit: 75% = \$730.00 85% = \$888.60	
		OMY with colon or jejunal replacement (abdominal and thorac dicle in the neck) - 1 surgeon (Anaes.) (Assist.)	ic mobilisation with
30550	Fee: \$2,126.65	Benefit: 75% = \$1595.00	
		OMY with colon or jejunal replacement (abdominal and thorac dicle in the neck) - conjoint surgery, principal surgeon (including	
30551	Fee: \$1,467.60	Benefit: 75% = \$1100.70	
		OMY with colon or jejunal replacement (abdominal and thorac dicle in the neck) - conjoint surgery, co-surgeon (Assist.)	ic mobilisation with
30553	Fee: \$1,085.55	Benefit: 75% = \$814.20 85% = \$1000.85	
	OESOPHAGECT	OMY with reconstruction by free jejunal graft - 1 surgeon (Ana	aes.) (Assist.)
30554	Fee: \$2,366.10	Benefit: 75% = \$1774.60	
		OMY with reconstruction by free jejunal graft - conjoint surgere) (Anaes.) (Assist.)	ry, principal surgeon
30556	Fee: \$1,632.20	Benefit: 75% = \$1224.15	
		OMY with reconstruction by free jejunal graft - conjoint surger	ry, co-surgeon (Assist.)
	1		

T8. SUF	RGICAL OPERAT	IONS 1. GENERAL
	OESOPHAGUS	, local excision for tumour of (Anaes.) (Assist.)
30559	Fee: \$876.10	Benefit: 75% = \$657.10 85% = \$791.40
	OESOPHAGEA	L PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.)
30560	Fee: \$973.30	Benefit: 75% = \$730.00
		Y or COLOSTOMY, closure of (not involving resection of bowel), on a person 10
	years of age or o	ver (Anaes.) (Assist.)
30562	Fee: \$613.55	Benefit: 75% = \$460.20
	(Assist.)	OR ILEOSTOMY, refashioning of, on a person 10 years of age or over (Anaes.)
30563	Fee: \$613.55	Benefit: 75% = \$460.20 85% = \$528.85
	SMALL BOWE	L STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.)
30564	Fee: \$796.40	Benefit: 75% = \$597.30
	SMALL INTEST (Assist.)	ΓΙΝΕ, resection of, without anastomosis (including formation of stoma) (Anaes.)
30565	Fee: \$898.55	Benefit: 75% = \$673.95
	SMALL INTES (Assist.)	ΓΙΝΕ, resection of, with anastomosis, on a person 10 years of age or over (Anaes.)
30566	Fee: \$998.10	Benefit: 75% = \$748.60
	INTRAOPERAT (Assist.)	TIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.)
30568	Fee: \$748.70	Benefit: 75% = \$561.55
		EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, piopsies (Anaes.) (Assist.)
30569	Fee: \$381.75	Benefit: 75% = \$286.35
	APPENDICECT over (Anaes.) (A	OMY, not being a service to which item 30574 applies on a person 10 years of age or ssist.)
30571	Fee: \$459.35	Benefit: 75% = \$344.55
	LAPAROSCOP	IC APPENDICECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)
30572	Fee: \$459.35	Benefit: 75% = \$344.55
	NOTE: Multiple	Operation and Multiple Anaesthetic rules apply to this item
		OMY, when performed in conjunction with any other intraabdominal procedure eincision (Anaes.)
30574	Fee: \$127.10	Benefit: 75% = \$95.35
	PANCREATIC dissection (Anae	ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic s.) (Assist.)
30575	Fee: \$528.70	Benefit: 75% = \$396.55
30577		NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION

T8. SUF	RGICAL OPERATION	ONS 1. GENERAL
	requiring major p	ancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)
	Fee: \$1,123.20	Benefit: 75% = \$842.40
		JMOUR, exploration of pancreas or duodenum, followed by local excision of r (Anaes.) (Assist.)
30578	Fee: \$1,183.05	Benefit: 75% = \$887.30
	ENDOCRINE TU tumour (Anaes.) (JMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal (Assist.)
30580	Fee: \$1,078.10	Benefit: 75% = \$808.60
	ENDOCRINE TU (Assist.)	JMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.)
30581	Fee: \$786.15	Benefit: 75% = \$589.65
	DISTAL PANCR	EATECTOMY (Anaes.) (Assist.)
30583	Fee: \$1,231.55	Benefit: 75% = \$923.70
	PANCREATICO pylorus (Anaes.)	-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of (Assist.)
30584	Fee: \$1,817.80	Benefit: 75% = \$1363.35
	PANCREATIC C means (Anaes.) (A	YST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic Assist.)
30586	Fee: \$723.20	Benefit: 75% = \$542.40
	PANCREATIC C	YST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)
30587	Fee: \$748.70	Benefit: 75% = \$561.55
	PANCREATICO	-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)
30589	Fee: \$1,290.15	Benefit: 75% = \$967.65
	PANCREATICO	-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)
30590	Fee: \$1,422.55	Benefit: 75% = \$1066.95
		OMY, near total or total (including duodenum), with or without splenectomy (Anaes.)
30593	Fee: \$1,946.70	Benefit: 75% = \$1460.05 85% = \$1862.00
	PANCREATECT resection (Anaes.)	OMY for pancreatitis following previously attempted drainage procedure or partial (Assist.)
30594	Fee: \$2,246.30	Benefit: 75% = \$1684.75
	SPLENORRHAP	HY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)
30596	Fee: \$925.30	Benefit: 75% = \$694.00
	SPLENECTOMY	(Anaes.) (Assist.)
30597	Fee: \$742.70	Benefit: 75% = \$557.05
30599	SPLENECTOMY	r, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal

T8. SUF	RGICAL OPERATION	ONS 1. GENERAL
	incision (Anaes.)	(Assist.)
	Fee: \$1,347.70	Benefit: 75% = \$1010.80
	DIAPHRAGMAT	TIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)
30600	Fee: \$801.40	Benefit: 75% = \$601.05
		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: \$987.20	Benefit: 75% = \$740.40
	PORTAL HYPER	RTENSION, porto-caval shunt for (Anaes.) (Assist.)
30602	Fee: \$1,602.25	Benefit: 75% = \$1201.70
	PORTAL HYPER	RTENSION, meso-caval shunt for (Anaes.) (Assist.)
30603	Fee: \$1,692.15	Benefit: 75% = \$1269.15 85% = \$1607.45
		RTENSION, selective spleno-renal shunt for (Anaes.) (Assist.)
30605	Fee: \$1,924.25	Benefit: 75% = \$1443.20
	PORTAL HYPER	RTENSION, oesophageal transection via stapler or oversew of gastric varices with or urisation (Anaes.) (Assist.)
30606	Fee: \$1,145.50	Benefit: 75% = \$859.15
		INE, resection of, with anastomosis, on a person under 10 years of age (Anaes.)
30608	Fee: \$1,297.55	Benefit: 75% = \$973.20
		NGUINAL HERNIA, laparoscopic repair of, not being a service associated with a tem 30614 applies (Anaes.) (Assist.)
30609	Fee: \$479.05	Benefit: 75% = \$359.30
	covered by item 3 sent for histologic	UR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipomas 1345 and lipomata - removal of by surgical excision, where the specimen excised is cal confirmation of diagnosis, on a person under 10 years of age, not being a service to m in this Group applies (Anaes.) (Assist.)
30611	Fee: \$580.95	Benefit: 75% = \$435.75 85% = \$496.25
		NGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to 3 or 30615 applies, on a person 10 years of age or over (Anaes.) (Assist.)
30614	Fee: \$479.05	Benefit: 75% = \$359.30
		ED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel rson 10 years of age or over (Anaes.) (Assist.)
30615	Fee: \$537.55	Benefit: 75% = \$403.20
		OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft nodes from one side of the neck, on a person under 10 years of age (Anaes.) (Assist.)
30618	(See para TN.8.24 c Fee: \$538.55	of explanatory notes to this Category) Benefit: 75% = \$403.95 85% = \$457.80

T8. SUF	RGICAL OPERATIO	NS 1. GENERA	
	LAPAROSCOPIC S	SPLENECTOMY, on a person under 10 years of age (Anaes.) (Assist.)	
30619	Fee: \$965.50	Benefit: 75% = \$724.15	
		atic umbilical, epigastric or linea alba hernia requiring mesh or other formal repair of age or over, other than a service to which item 30403 or 30405 applies (Anaes.)	
30621	Fee: \$420.20	Benefit: 75% = \$315.15	
	Gastrotomy, Reduct peptic ulcer, Simple	ostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, tion of intussusception, Removal of Meckel's diverticulum, Suture of perforated erepair of ruptured viscus, Reduction of volvulus, Pyloroplasty or Drainage of n under 10 years of age (Anaes.) (Assist.)	
30622	(See para TN.8.14 of 6 Fee: \$698.85	explanatory notes to this Category) Benefit: 75% = \$524.15	
		NVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other cedure is performed) on a person under 10 years of age (Anaes.) (Assist.)	
30623	Fee: \$698.85	Benefit: 75% = \$524.15	
		volving division of adhesions in conjunction with another intraabdominal procedure n to divide the adhesions is between 45 minutes and 2 hours, on a person under 10 .) (Assist.)	
30626	Fee: \$702.10	Benefit: 75% = \$526.60	
	LAPAROSCOPY, of person under 10 years	diagnostic, not being a service associated with any other laparoscopic procedure, on ars of age (Anaes.)	
30627	(See para TN.8.15 of 6 Fee: \$294.90	explanatory notes to this Category) Benefit: 75% = \$221.20	
	HYDROCELE, tapp	ping of	
30628	Fee: \$36.70	Benefit: 75% = \$27.55 85% = \$31.20	
	Orchidectomy, radical, including spermatic cord, unilateral, for tumour, inguinal approach, 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.)		
30629	Fee: \$537.55	Benefit: 75% = \$403.20	
_	Insertion of testicula	ar prosthesis, at least 6 months following orchidectomy (Anaes.) (Assist.)	
Fee 30630	Fee: \$488.55	Benefit: 75% = \$366.45	
	Hydrocele, removal 30644 applies (Anac	of, other than a service associated with a service to which item 30641, 30642 or es.)	
30631	Fee: \$244.05	Benefit: 75% = \$183.05 85% = \$207.45	
	with a service to wh	correction of, including microsurgical techniques, other than a service associated nich item 30390, 30627, 30641, 30642 or 30644 applies—one procedure (Anaes.)	
	(Assist.)		

18. SUF	RGICAL OPERATI	IONS 1. GENERAL
		Y BUTTON, caecostomy antegrade enema device (chait etc) and/or stomal indwelling escopic insertion of, or non-endoscopic replacement of, on a person under 10 years of
30636	Fee: \$240.45	Benefit: 75% = \$180.35 85% = \$204.40
	ENTEROSTOM years of age (Ana	Y or COLOSTOMY, closure of not involving resection of bowel, on a person under 10 aes.) (Assist.)
30637	Fee: \$797.70	Benefit: 75% = \$598.30
	COLOSTOMY (OR ILEOSTOMY, refashioning of, on a person under 10 years of age (Anaes.) (Assist.)
30639	Fee: \$797.70	Benefit: 75% = \$598.30 85% = \$713.00
		nd irreducible scrotal hernia, where duration of surgery exceeds 2 hours, in a person 10 ver, other than a service to which item 30403, 30405, 30614, 30615 or 30621 applies
30640	Fee: \$943.55	Benefit: 75% = \$707.70
	ORCHIDECTON (Anaes.) (Assist.)	MY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis
30641	Fee: \$420.20	Benefit: 75% = \$315.15
	insertion of testic	adical, including spermatic cord, unilateral, for tumour, inguinal approach, with cular prosthesis, other than a service associated with a service to which item 30631, 20643, 30644 or 45051 applies (Anaes.) (Assist.)
30642	Fee: \$781.85	Benefit: 75% = \$586.40
	excision of spern	permatic cord, inguinal approach, with or without testicular biopsy, with or without natic cord lesion, for a patient under 10 years of age, other than a service associated which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)
30643	Fee: \$698.85	Benefit: 75% = \$524.15
	excision of spern	permatic cord, inguinal approach, with or without testicular biopsy, with or without natic cord lesion, for a patient at least 10 years of age, other than a service associated which item 30629, 30630 or 30642 applies (Anaes.) (Assist.)
30644	Fee: \$537.55	Benefit: 75% = \$403.20
	APPENDICECT age (Anaes.) (As	OMY, not being a service to which item 30574 applies, on a person under 10 years of sist.)
30645	Fee: \$597.05	Benefit: 75% = \$447.80
	LADADOGGODI	IC APPENDICECTOMY, on a person under 10 years of age (Anaes.) (Assist.)
	LAPAROSCOPI	ATTENDICECTOWT, on a person under to years of age (Anaes.) (Assist.)
30646	Fee: \$597.05	Benefit: 75% = \$447.80
	Fee: \$597.05	Benefit: 75% = \$447.80 GE, arrest of, following circumcision requiring general anaesthesia on a person under 10
	Fee: \$597.05	Benefit: 75% = \$447.80 GE, arrest of, following circumcision requiring general anaesthesia on a person under 10
30646	Fee: \$597.05 HAEMORRHAC years of age (Ana Fee: \$193.50	Benefit: 75% = \$447.80 GE, arrest of, following circumcision requiring general anaesthesia on a person under 10 aes.)

T8. SUR	GICAL OPERAT	IONS	1. GENERAL
		the penis, when performed under general or regional a which an item in Group T7 or Group T10 applies (An	
30658	Fee: \$146.40	Benefit: 75% = \$109.80 85% = \$124.45	
	HAEMORRHAO of age or over (A	GE, arrest of, following circumcision requiring general anaes.)	anaesthesia on a person 10 years
30663	Fee: \$148.85	Benefit: 75% = \$111.65 85% = \$126.55	
		S or PHIMOSIS, reduction of, under general anaestheng a service associated with a service to which another	
30666	Fee: \$48.90	Benefit: 75% = \$36.70 85% = \$41.60	
	COCCYX, excis	ion of (Anaes.) (Assist.)	
30672	Fee: \$459.35	Benefit: 75% = \$344.55	
		NUS OR CYST, OR SACRAL SINUS OR CYST, exc	ision of (Anaes.)
30676	Fee: \$390.90	Benefit: 75% = \$293.20 85% = \$332.30	
	PILONIDAL SI	NUS, injection of sclerosant fluid under anaesthesia (A	anaes.)
30679	Fee: \$99.30	Benefit: 75% = \$74.50 85% = \$84.45	
		procedural therapy, for diagnosis of patients with obsc th another item in this subgroup (with the exception o	
	The patient to wl	hom the service is provided must:	
	(i) have recurre	ent 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 Fee: \$1,206.55	of explanatory notes to this Category) Benefit: 75% = \$904.95 85% = \$1121.85	
	WITHOUT intra	copy, examination of the small bowel (anal approach), approcedural therapy, for diagnosis of patients with obscith another item in this subgroup (with the exception of	eure gastrointestinal bleeding, not
	The patient to wl	hom the service is provided must:	
	(i) have recurre	ent or persistent bleeding; and	
	(ii) be anaemic	or have active bleeding; and	

T8. SUR	GICAL OPERATIONS 1. GENERAL
	the cause of the bleeding.
	(Anaes.)
	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,206.55 Benefit: 75% = \$904.95 85% = \$1121.85
	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.)
30684	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,484.85 Benefit: 75% = \$1113.65 85% = \$1400.15
	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.)
30686	(See para TN.8.17 of explanatory notes to this Category) Fee: \$1,484.85 Benefit: 75% = \$1113.65 85% = \$1400.15
	ENDOSCOPY with RADIOFREQUENCY ABLATION of mucosal metaplasia for the treatment of Barrett's Oesophagus in a single course of treatment, following diagnosis of high grade dysplasia confirmed by histological examination (Anaes.)
30687	(See para TN.8.17, TN.8.20 of explanatory notes to this Category) Fee: \$490.95 Benefit: 75% = \$368.25 85% = \$417.35
30688	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$376.30 Benefit: 75% = \$282.25 85% = \$319.90
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30690	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$580.90 Benefit: 75% = \$435.70 85% = \$496.20
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30692	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$376.30 Benefit: 75% = \$282.25 85% = \$319.90
	Endoscopic ultrasound (endoscopy with ultrasound imaging), with or without biopsy, with fine needle aspiration, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup (other than item 30484, 30485, 30491 or 30494) and other than a service associated with the routine monitoring of chronic pancreatitis. (Anaes.)
30694	(See para TN.8.21, TN.8.17 of explanatory notes to this Category) Fee: \$580.90 Benefit: 75% = \$435.70 85% = \$496.20
	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) Fee: \$599.05 Benefit: 75% = \$449.30 85% = \$514.35
	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) Fee: \$748.70 Benefit: 75% = \$561.55 85% = \$664.00
	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) Fee: \$898.55 Benefit: 75% = \$673.95 85% = \$813.85
31003	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

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	sections
	Not applicable to a service performed in association with a service to which item 31000 applies (Anaes.)
	(See para TN.8.151 of explanatory notes to this Category) Fee: \$599.05 Benefit: 75% = \$449.30 85% = \$514.35
	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) Fee: \$748.70 Benefit: 75% = \$561.55 85% = \$664.00
	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—13 or more sections
	Not applicable to a service performed in association with a service to which item 31002 applies (Anaes.)
31005	(See para TN.8.151 of explanatory notes to this Category) Fee: \$898.55 Benefit: 75% = \$673.95 85% = \$813.85
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:
	(a) the lesion size is not more than 10 mm in diameter; and
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and
	(c) the specimen excised is sent for histological examination (Anaes.)
31206	Fee: \$98.45 Benefit: 75% = \$73.85 85% = \$83.70
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:
	(a) the lesion size is more than 10 mm, but not more than 20 mm, in diameter; and
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and
	(c) the specimen excised is sent for histological examination (Anaes.)
31211	Fee: \$126.95 Benefit: 75% = \$95.25 85% = \$107.95
	Tumour, cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), removal of and suture, if:
	(a) the lesion size is more than 20 mm in diameter; and
	(b) the removal is from a mucous membrane by surgical excision (other than by shave excision); and
	(c) the specimen excised is sent for histological examination (Anaes.)
31216	Fee: \$148.05 Benefit: 75% = \$111.05 85% = \$125.85

T8. SUF	RGICAL OPERATIONS	1. GENERAL
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulce (other than scars removed during the surgical approach at an operation), removal of 4 to 1 suture, if:	
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from cutaneous or subcutaneous tissue by surgical excision (other the excision); and	han by shave
	(c) all of the specimens excised are sent for histological examination (Anaes.)	
31220	Fee: \$221.25 Benefit: 75% = \$165.95 85% = \$188.10	
	Tumours, cysts, ulcers or scars (other than scars removed during the surgical approach at removal of 4 to 10 lesions, if:	an operation),
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from a mucous membrane by surgical excision (other than by shave	excision); and
	(c) each site of excision is closed by suture; and	
	(d) all of the specimens excised are sent for histological examination (Anaes.)	
31221	Fee: \$221.25 Benefit: 75% = \$165.95 85% = \$188.10	
	Tumours (other than viral verrucae (common warts) and seborrheic keratoses), cysts, ulce (other than scars removed during the surgical approach at an operation), removal of more lesions, if:	
	(a) the size of each lesion is not more than 10 mm in diameter; and	
	(b) each removal is from cutaneous or subcutaneous tissue or mucous membrane by sur (other than by	gical excision
	shave excision); and	
	(c) each site of excision is closed by suture; and	
	(d) all of the specimens excised are sent for histological examination (Anaes.)	
31225	Fee: \$393.20 Benefit: 75% = \$294.90 85% = \$334.25	
	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPF HIDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NU (excision from face or neck) (Anaes.)	
31245	(See para TN.8.23 of explanatory notes to this Category) Fee: \$380.50 Benefit: 75% = \$285.40 85% = \$323.45	
	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body the specimen excised is sent for histological confirmation of diagnosis (Anaes.)	y surface <i>where</i>
31250	Fee: \$380.50 Benefit: 75% = \$285.40 85% = \$323.45	
	Muscle, bone or cartilage, excision of one or more of, if clinically indicated, and if:	
31340	(a) the specimen excised is sent for histological confirmation; and	

T8. SUF	RGICAL OPERATIONS 1. GENER	₹AL
	(b) a malignant tumour of skin covered by item 31000, 31001, 31002, 31003, 31004, 31005, 31356, 31358, 31359, 31361, 31363, 31365, 31367, 31369, 31371, 31372, 31373, 31374, 31375 or 31376 is excised (Anaes.)	
	Derived Fee: 75% of the fee for excision of malignant tumour	
	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and 50mm or more in diameter, or is sub-fascial, where the specimen is sent for histological confirmation of diagnot (Anaes.)	
31345	Fee: \$217.55 Benefit: 75% = \$163.20 85% = \$184.95	
	Liposuction (suction assisted lipolysis) to one regional area for contour problems of abdominal, uppe arm or thigh fat because of repeated insulin injections, if:	r
	(a) the lesion is subcutaneous; and	
	(b) the lesion is 50 mm or more in diameter; and	
	(c) photographic and/or diagnostic imaging evidence demonstrating the need for this service is documented in the patient notes (Anaes.)	
31346	(See para TN.8.101 of explanatory notes to this Category) Fee: \$217.55 Benefit: 75% = \$163.20 85% = \$184.95	
	BENIGN TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage, and bone, simple lipom covered by item 31345 and lipomata, removal of by surgical excision, where the specimen excised is sent for histological confirmation of diagnosis, on a person 10 years of age or over, not being a service which another item in this Group applies (Anaes.) (Assist.)	
31350	Fee: \$446.90 Benefit: 75% = \$335.20 85% = \$379.90	
	MALIGNANT TUMOUR of SOFT TISSUE, excluding tumours of skin, cartilage and bone, removal by surgical excision, where <i>histological proof of malignancy has been obtained</i> , not being a service twhich another item in this Group applies (Anaes.) (Assist.)	
31355	Fee: \$736.80 Benefit: 75% = \$552.60 85% = \$652.10	
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31373, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:	74,
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguou area; and	S
	(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) Fee: \$228.25 Benefit: 75% = \$171.20 85% = \$194.05	
	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:	ı),
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguou	

T8. SUF	RGICAL OPERATIONS 1. GENERAL
	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.)
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$113.10 Benefit: 75% = \$84.85 85% = \$96.15
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from a contiguous 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.)
31358	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$279.35 Benefit: 75% = \$209.55 85% = \$237.45
	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), if:
	(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) Fee: \$340.50 Benefit: 75% = \$255.40
	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 6 mm or more; and
	(c) the excised specimen is sent for histological examination (Anaes.)
21262	(See para TN.8.22, TN.8.125 of explanatory notes to this Category)
31360	Fee: \$173.30 Benefit: 75% = \$130.00 85% = \$147.35 Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374,
31361	31375 or 31376), surgical excision (other than by shave excision) and repair of, if:

T8. SUF	RGICAL OPERATIONS 1. GENERAL				
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the				
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and				
	(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.)				
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$192.55 Benefit: 75% = \$144.45 85% = \$163.70				
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:				
	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the				
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and				
	(b) the necessary excision diameter is less than 14 mm; and				
	(c) the excised specimen is sent for histological examination;				
	not in association with item 45201 (Anaes.)				
31362	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$138.10 Benefit: 75% = \$103.60 85% = \$117.40				
	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 face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the				
	knee) or distal upper limb (distal to, and including, the ulnar styloid); and				
	(b) the necessary excision diameter is 14 mm or more; and				
	(c) the excised specimen is sent for histological examination; and				
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)				
31363	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$251.90 Benefit: 75% = \$188.95 85% = \$214.15				
	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:				
242.51	(a) the lesion is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal to, and including, the				
31364					

T8. SUR	GICAL OPERATIONS 1. GENERAL
	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.)
	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$173.30 Benefit: 75% = \$130.00 85% = \$147.35
	Malignant skin lesion (other than a malignant skin lesion covered by item 31369, 31370, 31371, 31372 or 31373), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and
	(b) the necessary excision diameter is less than 15 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
31365	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$163.25 Benefit: 75% = \$122.45 85% = \$138.80
	Non-malignant skin lesion (other than viral verrucae (common warts) and seborrheic keratoses), including a cyst, ulcer or scar (other than a scar removed during the surgical approach at an operation), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31357, 31360, 31362 or 31364; and
	(b) the necessary excision diameter is less than 15 mm; and
	(c) the excised specimen is sent for histological examination;
	not in association with item 45201 (Anaes.)
31366	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$98.45 Benefit: 75% = \$73.85 85% = \$83.70
	Malignant skin lesion (other than a malignant skin lesion covered by item 31371, 31372, 31373, 31374, 31375 or 31376), surgical excision (other than by shave excision) and repair of, if:
	(a) the lesion is excised from any part of the body not covered by item 31356, 31358, 31359, 31361 or 31363; and
	(b) the necessary excision diameter is at least 15 mm but not more than 30 mm; and
	(c) the excised specimen is sent for histological examination; and
	(d) malignancy is confirmed from the excised specimen or previous biopsy;
	not in association with item 45201 (Anaes.)
31367	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$220.25 Benefit: 75% = \$165.20 85% = \$187.25

T8. SUR	GICAL OPERATIONS	1. GENERAL			
	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) Fee: \$129.45 Benefit: 75% = \$97.10 85% = \$110.05				
	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:	2, 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 more than 30 mm; and				
	(c) the excised specimen is sent for histological examination; and				
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)				
31369	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$253.60 Benefit: 75% = \$190.20 85% = \$215.60				
	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 more than 30 mm; and				
	(c) the excised specimen is sent for histological examination (Anaes.)				
31370	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$148.05 Benefit: 75% = \$111.05 85% = \$125.85				
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of sl carcinoma of skin, definitive surgical excision (other than by shave excision) and repair				
	(a) the tumour is excised from nose, eyelid, eyebrow, lip, ear, digit or genitalia, or from area; and	om a contiguous			
	(b) the necessary excision diameter is 6 mm or more; and				
	(c) the excised specimen is sent for histological examination; and				
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)				
31371	(See para TN.8.22, TN.8.125 of explanatory notes to this Category)				

T8. SUR	GICAL OPERATIONS	1. GENERAL				
	Fee: \$368.15 Benefit: 75% = \$276.15 85% = \$312.95					
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and reparations.					
	(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 less than 14 mm; and					
	(c) the excised specimen is sent for histological examination; and					
	(d) malignancy is confirmed from the excised specimen or previous biopsy;					
	not in association with item 45201 (Anaes.)					
31372	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$318.35 Benefit: 75% = \$238.80 85% = \$270.60					
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and reparations.					
	 (a) the tumour is excised from face, neck, scalp, nipple-areola complex, distal lower limb (distal and including, the knee) or distal upper limb (distal to, and including, the ulnar styloid); and (b) the necessary excision diameter is 14 mm or more; and 					
	(c) the excised specimen is sent for histological examination; and					
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)					
31373	(See para TN.8.23, TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$367.95 Benefit: 75% = \$276.00 85% = \$312.80					
	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) Fee: \$290.70 Benefit: 75% = \$218.05 85% = \$247.10					
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of carcinoma of skin, definitive surgical excision (other than by shave excision) and report					
31375	(a) the tumour is excised from any part of the body not covered by item 31371, 313	372 or 31373; and				

T8. SUR	RGICAL OPERATIONS 1.	GENERAL		
	(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.)			
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category) Fee: \$312.85 Benefit: 75% = \$234.65 85% = \$265.95			
	Malignant melanoma, appendageal carcinoma, malignant connective tissue tumour of skin or mer carcinoma of skin, definitive surgical excision (other than by shave excision) and repair of, if:			
	(a) the tumour is excised from any part of the body not covered by item 31371, 31372 or 3	31373; and		
	(b) the necessary excision diameter is more than 30 mm; and			
	(c) the excised specimen is sent for histological examination; and			
	(d) malignancy is confirmed from the excised specimen or previous biopsy (Anaes.)			
	(See para TN.8.22, TN.8.125 of explanatory notes to this Category)			
31376	Fee: \$362.60 Benefit: 75% = \$271.95 85% = \$308.25			
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to and including 20mm i (excluding tumour of the lip), excision of, where histological confirmation of malignancy ha obtained (Anaes.) (Assist.)			
31400	Fee: \$269.25 Benefit: 75% = \$201.95 85% = \$228.90			
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to including 40mm in diameter (excluding tumour of the lip), excision of, where histological coof malignancy has been obtained (Anaes.) (Assist.)			
31403	Fee: \$310.75 Benefit: 75% = \$233.10			
	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes.) (Assist.)			
31406	Fee: \$517.85 Benefit: 75% = \$388.40 85% = \$440.20			
	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)			
31409	Fee: \$1,608.90 Benefit: 75% = \$1206.70			
	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervic (Anaes.) (Assist.)	al approach		
31412	Fee: \$1,981.80 Benefit: 75% = \$1486.35			
	LYMPH NODE OF NECK, biopsy of (Anaes.)			
31420	Fee: \$189.65 Benefit: 75% = \$142.25 85% = \$161.25			
	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving remetissue and lymph nodes from one side of the neck, on a person 10 years of age or over (Anae			
31423	(See para TN.8.24 of explanatory notes to this Category) Fee: \$414.30 Benefit: 75% = \$310.75 85% = \$352.20			

T8. SUF	RGICAL OPERATIONS 1. GENERA
	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes.) (Assist.)
31426	(See para TN.8.24 of explanatory notes to this Category) Fee: \$828.55 Benefit: 75% = \$621.45
	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) Fee: \$1,291.25 Benefit: 75% = \$968.45
	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoi dissections) (Anaes.) (Assist.)
31432	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,381.00 Benefit: 75% = \$1035.75
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.)
31435	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,015.05 Benefit: 75% = \$761.30
	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes.) (Assist.)
31438	(See para TN.8.24 of explanatory notes to this Category) Fee: \$1,608.90 Benefit: 75% = \$1206.70
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is hour or less (Anaes.) (Assist.)
31450	Fee: \$419.35 Benefit: 75% = \$314.55
	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.)
31452	Fee: \$733.75 Benefit: 75% = \$550.35
	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.)
31454	Fee: \$580.90 Benefit: 75% = \$435.70
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.)
31456	Fee: \$253.25 Benefit: 75% = \$189.95
	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.)
31458	Fee: \$303.85 Benefit: 75% = \$227.90
	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.)
31460	Fee: \$368.15 Benefit: 75% = \$276.15
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestina

T8. SUF	RGICAL OPERATION	ONS 1. GENER	
	resection (Anaes.)	(Assist.)	
	Fee: \$537.55	Benefit: 75% = \$403.20	
	without closure of	PERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or the diaphragmatic hiatus, by laparoscopic technique - not being a service to which is (Anaes.) (Assist.)	
31464	(See para TN.8.19 c Fee: \$898.55	of explanatory notes to this Category) Benefit: 75% = \$673.95	
		PERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation	
31466	(See para TN.8.19 o Fee: \$1,347.75	of explanatory notes to this Category) Benefit: 75% = \$1010.85	
		AGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection chiatus, with or without fundoplication (Anaes.) (Assist.)	
31468	Fee: \$1,480.70	Benefit: 75% = \$1110.55	
	LAPAROSCOPIO	C SPLENECTOMY, on a person 10 years of age or over (Anaes.) (Assist.)	
31470	Fee: \$742.70	Benefit: 75% = \$557.05	
	CHOLEDOCHO	DUODENOSTOMY, CHOLECYSTOENTEROSTOMY, EJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgered (Anaes.) (Assist.)	
31472	Fee: \$1,206.35	Benefit: 75% = \$904.80	
		GN LESION up to and including 50mm in diameter, including simple cyst, ibrocystic disease, open surgical biopsy or excision of, with or without frozen section)	
31500	(See para TN.8.25 of Fee: \$268.15	of explanatory notes to this Category) Benefit: 75% = \$201.15 85% = \$227.95	
	BREAST, BENIC	GN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.)	
31503	(See para TN.8.25 of Fee: \$357.60	of explanatory notes to this Category) Benefit: 75% = \$268.20 85% = \$304.00	
		RMALITY detected by mammography or ultrasound where guidewire or other dure is performed, excision biopsy of (Anaes.) (Assist.)	
31506	(See para TN.8.25 c Fee: \$402.30	of explanatory notes to this Category) Benefit: 75% = \$301.75	
	BREAST, MALIO (Anaes.)	GNANT TUMOUR, open surgical biopsy of, with or without frozen section histolog	
31509	(See para TN.8.25 o Fee: \$357.60	of explanatory notes to this Category) Benefit: 75% = \$268.20 85% = \$304.00	
	BREAST, MALIC histology (Anaes.	GNANT TUMOUR, complete local excision of, with or without frozen section (Assist.)	
31512	Fee: \$670.45	Benefit: 75% = \$502.85	
31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant		

T8. SUR	RGICAL OPERATIONS	1. GENERAL	
	tumour (Anaes.) (Assist.)		
	(See para TN.8.25 of explanatory notes to this Category) Fee: \$449.80 Benefit: 75% = \$337.35		
	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without fr histology when targeted intraoperative radiation therapy (using an Intrabeam® or X device) is performed concurrently, if the patient satisfies the requirements mentione (g) of item 15900	oft® Axxent®	
Amend	Applicable only once per breast per lifetime (H) (Anaes.) (Assist.)		
31516	Fee: \$894.05 Benefit: 75% = \$670.55		
	BREAST, total mastectomy (H) (Anaes.) (Assist.)		
31519	Fee: \$759.05 Benefit: 75% = \$569.30		
	BREAST, subcutaneous mastectomy (H) (Anaes.) (Assist.)		
31524	Fee: \$1,072.75 Benefit: 75% = \$804.60		
	BREAST, mastectomy for gynecomastia, with or without liposuction (suction assist being a service associated with a service to which item 45585 applies (H) (Anaes.)	* · · · · · · · · · · · · · · · · · · ·	
31525	Fee: \$536.20 Benefit: 75% = \$402.15		
	guidance, for histological examination, if imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than one cm in diameter; including pre-operative localisation of lesion, if performed, other than a service assot to which item 31548 applies	ociated with a service	
31530	Fee: \$614.30 Benefit: 75% = \$460.75 85% = \$529.60		
	FINE NEEDLE ASPIRATION of an impalpable breast lesion detected by mammography or ultrasound imaging guided - but not including imaging (Anaes.)		
31533	(See para TN.8.26 of explanatory notes to this Category) Fee: \$142.20 Benefit: 75% = \$106.65 85% = \$120.90		
	Breast, preoperative localisation of lesion of, by hookwire or similar device, using i imaging techniques, but not including imaging (Anaes.) (Anaes.)	nterventional	
31536	Fee: \$195.35 Benefit: 75% = \$146.55 85% = \$166.05		
	Breast, biopsy of solid tumour or tissue of, using mechanical biopsy device, for histologica examination, other than a service associated with a service to which item 31530 applies (A (Anaes.)		
31548	(See para TN.8.26 of explanatory notes to this Category) Fee: \$206.25 Benefit: 75% = \$154.70 85% = \$175.35		
	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION inclugranulomatous mastitis or similar, exploration and drainage of when undertaken in of a hospital, excluding aftercare (Anaes.)	•	
31551	Fee: \$223.50 Benefit: 75% = \$167.65		
31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERAT	IONS 1. GE	ENERAL	
	Fee: \$447.05	Benefit: 75% = \$335.30		
	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)			
31557	Fee: \$357.60	Benefit: 75% = \$268.20 85% = \$304.00		
	ACCESSORY B	BREAST TISSUE, excision of (Anaes.) (Assist.)		
31560	Fee: \$357.60 Extended Medic	Benefit: 75% = \$268.20 85% = \$304.00 care Safety Net Cap: \$286.10		
		PPLE, surgical eversion of (Anaes.)		
31563	Fee: \$267.85	Benefit: 75% = \$200.90 85% = \$227.70		
	ACCESSORY N	NIPPLE, excision of (Anaes.)		
31566	Fee: \$134.05	Benefit: 75% = \$100.55 85% = \$113.95		
	A divistable meetri	BARIATRIC		
		ic band, placement of, with or without crural repair taking 45 minutes or less, for ically severe obesity (Anaes.) (Assist.)	та	
31569	(See para TN.8.29 Fee: \$876.10	of explanatory notes to this Category) Benefit: 75% = \$657.10		
	minutes or less, i	y Roux-en-Y including associated anastomoses, with or without crural repair ta for a patient with clinically severe obesity not being associated with a service to ies (Anaes.) (Assist.)		
31572	(See para TN.8.29 Fee: \$1,078.10	of explanatory notes to this Category) Benefit: 75% = \$808.60		
	Sleeve gastrectomy, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)			
31575	(See para TN.8.29 Fee: \$876.10	of explanatory notes to this Category) Benefit: 75% = \$657.10		
	Gastroplasty (excluding by gastric plication), with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)			
31578	(See para TN.8.29 of explanatory notes to this Category) Fee: \$876.10 Benefit: 75% = \$657.10			
	Gastric bypass by biliopancreatic diversion with or without duodenal switch including gastric resection and anastomoses, with or without crural repair taking 45 minutes or less, for a patient with clinically severe obesity (Anaes.) (Assist.)			
31581	(See para TN.8.29 Fee: \$1,078.10	of explanatory notes to this Category) Benefit: 75% = \$808.60		
	gastroplasty (exc	of adjustable gastric banding (removal or replacement of gastric band), gastric bluding by gastric plication) or biliopancreatic diversion being services to which apply (Anaes.) (Assist.)		
31584	(See para TN.8.30 Fee: \$1,587.20	of explanatory notes to this Category) Benefit: 75% = \$1190.40		
	Adjustment of ga	astric band as an independent procedure including any associated consultation		
	Fee: \$101.00	Benefit: 75% = \$75.75 85% = \$85.85		

T8. SUF	RGICAL OPERAT	IONS	1. GENERAL
	Adjustment of ga	astric band reservoir, repair, re	evision or replacement of (Anaes.) (Assist.)
31590	Fee: \$259.60	Benefit: 75% = \$194.70	85% = \$220.70
T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL
	Group T8. Surgi	cal Operations	
		Sub	group 2. Colorectal
		TINE, resection of, without an na) (Anaes.) (Assist.)	astomosis, including right hemicolectomy (including
32000	Fee: \$1,063.55	Benefit: 75% = \$797.70	
	LARGE INTEST	TINE, resection of, with anaste	omosis, including right hemicolectomy (Anaes.) (Assist.)
32003	Fee: \$1,112.50	Benefit: 75% = \$834.40	
	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flex without anastomosis, not being a service associated with a service to which item 32000, 32003, 3200 32006 applies (Anaes.) (Assist.)		
32004	Fee: \$1,186.30	Benefit: 75% = \$889.75	
	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splen with anastomosis, not being a service associated with a service to which item 32000, 32003, 3 32006 applies (Anaes.) (Assist.)		
32005	Fee: \$1,340.15	Benefit: 75% = \$1005.15	
	LEFT HEMICOI stoma) (Anaes.)	_	scending and sigmoid colon (including formation of
32006	Fee: \$1,186.30	Benefit: 75% = \$889.75	
	TOTAL COLEC	TOMY AND ILEOSTOMY	(Anaes.) (Assist.)
32009	Fee: \$1,407.25	Benefit: 75% = \$1055.45	
	TOTAL COLEC	TOMY AND ILEORECTAL	ANASTOMOSIS (Anaes.) (Assist.)
32012	Fee: \$1,554.45	Benefit: 75% = \$1165.85	
	TOTAL COLEC (Assist.)	TOMY WITH EXCISION O	F RECTUM AND ILEOSTOMY 1 surgeon (Anaes.)
32015	Fee: \$1,910.40	Benefit: 75% = \$1432.80	
			F RECTUM AND ILEOSTOMY, COMBINED (AL RESECTION (including aftercare) (Anaes.) (Assist.)
32018	Fee: \$1,619.95	Benefit: 75% = \$1215.00	
		TOMY WITH EXCISION O IS OPERATION; PERINEAL	F RECTUM AND ILEOSTOMY, COMBINED L RESECTION (Assist.)
32021	Fee: \$580.90	Benefit: 75% = \$435.70	
32023		tion of stent or stents for large any image intensification, wh	e bowel obstruction, stricture or stenosis, including nere the obstruction is due to:

T8. SUF	RGICAL OPERATION	ONS	2. COLORECTAL	
	a) a pre-dia	gnosed colorectal cancer, or cancer of an organ	adjacent to the bowel; or	
	b) an unkn	own diagnosis (Anaes.)		
	(See para TN.8.17 o	of explanatory notes to this Category)		
	Fee: \$572.70	Benefit: 75% = \$429.55		
	ANASTOMOSIS	RESTORATIVE ANTERIOR RESECTION V (of the rectum) greater than 10 centimetres from ne not being a service associated with a service Assist.)	m the anal verge excluding resection of	
32024	Fee: \$1,407.25	Benefit: 75% = \$1055.45		
	ANASTOMOSIS	RESTORATIVE ANTERIOR RESECTION W (of the rectum) less than 10 centimetres from the service associated with a service to which item	he anal verge, with or without covering	
32025	Fee: \$1,882.30	Benefit: 75% = \$1411.75		
		A LOW RESTORATIVE RESECTION, with ed in the anorectal region and is 6cm or less fro		
32026	Fee: \$2,027.05	Benefit: 75% = \$1520.30		
		OR ULTRA LOW RESTORATIVE RESECTI	ON, with peranal sutured coloanal	
	anastomosis, with	or without covering stoma (Anaes.) (Assist.)		
32028	Fee: \$2,172.00	Benefit: 75% = \$1629.00		
		RVOIR, construction of, being a service associoup applies (Anaes.) (Assist.)	ated with a service to which any other	
32029	Fee: \$434.35	Benefit: 75% = \$325.80		
	RECTOSIGMOII	DECTOMY (Hartmann's operation) (Anaes.) (A	Assist.)	
32030	Fee: \$1,063.55	Benefit: 75% = \$797.70		
	RESTORATION stoma (Anaes.) (A	OF BOWEL following Hartmann's or similar oassist.)	peration, including dismantling of the	
32033	Fee: \$1,554.45	Benefit: 75% = \$1165.85		
	SACROCOCCYO	GEAL AND PRESACRAL TUMOUR excision	n of (Anaes.) (Assist.)	
32036	Fee: \$1,971.55	Benefit: 75% = \$1478.70		
		ANUS, ABDOMINOPERINEAL RESECTION	OF 1 surgeon (Anaes.) (Assist.)	
32039	Fee: \$1,583.00	Benefit: 75% = \$1187.25		
	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.)			
32042	Fee: \$1,333.55	Benefit: 75% = \$1000.20		
		ANUS, ABDOMINOPERINEAL RESECTION rineal resection (Assist.)	OF, COMBINED SYNCHRONOUS	
32045	Fee: \$499.10	Benefit: 75% = \$374.35		

T8. SUF	RGICAL OPERATION	ONS	2. COLORECTAL
		NUS, abdomino-perineal resection of, cor e perineal surgeon also provides assistan	
32046	Fee: \$771.25	Benefit: 75% = \$578.45	
	PERINEAL PRO	CTECTOMY (Anaes.) (Assist.)	
32047	Fee: \$898.55	Benefit: 75% = \$673.95	
		COMY with excision of rectum and ileoar without creation of temporary ileostomy	
32051	Fee: \$2,388.95	Benefit: 75% = \$1791.75	
	reservoir, with or	OMY with excision of rectum and ileoar without creation of temporary ileostomy re) (Anaes.) (Assist.)	
32054	Fee: \$2,192.60	Benefit: 75% = \$1644.45	
		OMY with excision of rectum and ileoar surgery, perineal surgeon (Assist.)	nal anastomosis with formation of ileal
32057	Fee: \$580.90	Benefit: 75% = \$435.70	
		OSURE with rectal resection and mucosoreservoir, with or without temporary loop	
32060	Fee: \$2,388.95	Benefit: 75% = \$1791.75	
	formation of ileal	OSURE with rectal resection and mucosoreservoir, with or without temporary loop g aftercare) (Anaes.) (Assist.)	
32063	Fee: \$2,192.60	Benefit: 75% = \$1644.45	
		OSURE with rectal resection and mucosoreservoir, with or without temporary loop	
32066	Fee: \$580.90	Benefit: 75% = \$435.70	
	ILEOSTOMY RE where appropriate		ncluding conversion of existing ileostomy
32069	Fee: \$1,767.15	Benefit: 75% = \$1325.40	
	SIGMOIDOSCOI	PIC EXAMINATION (with rigid sigmoid	loscope), with or without biopsy
32072	Fee: \$49.35	Benefit: 75% = \$37.05 85% = \$41.95	
			loscope), UNDER GENERAL ce associated with a service to which another
32075	Fee: \$77.40	Benefit: 75% = \$58.05 85% = \$65.80	
		colonoscopy up to the hepatic flexure, we service to which any of items 32222 to 32	with or without biopsy, other than a service 2228 applies.
32084			
J200 1			

T8. SUF	RGICAL OPERATIONS		2. COLORECTAL
	(Anaes.)		
	(See para TN.8.17, TN.8.134 of explanat Fee: \$114.85 Benefit: 75% =	sory notes to this Category) \$86.15 85% = \$97.65	
		n up to the hepatic flexure by sigmoidosc r than a service associated with a service	
	(Anaes.)		
32087	(See para TN.8.17, TN.8.134 of explanat Fee: \$211.10 Benefit: 75% =	ory notes to this Category) \$158.35 85% = \$179.45	
	ENDOSCOPIC DILATATION OF C	COLORECTAL STRICTURES includin	g colonoscopy (Anaes.)
32094	(See para TN.8.17 of explanatory notes to Fee: \$569.10 Benefit: 75% =		
	ENDOSCOPIC EXAMINATION of or without biopsies (Anaes.)	SMALL BOWEL with flexible endosco	ope passed by stoma, with
32095	(See para TN.8.17 of explanatory notes to Fee: \$131.80 Benefit: 75% =	o this Category) \$98.85 85% = \$112.05	
	RECTAL BIOPSY, full thickness, unnerve block where undertaken in a ho	nder general anaesthesia, or under epidus ospital (Anaes.) (Assist.)	ral or spinal (intrathecal)
32096	Fee: \$264.95 Benefit: 75% =	\$198.75	
	RECTAL TUMOUR of 5 centimetre (Assist.)	s or less in diameter, per anal submucos	al excision of (Anaes.)
32099	Fee: \$343.65 Benefit: 75% =	\$257.75	
	RECTAL TUMOUR of greater than per anal submucosal excision of (Ana	5 centimetres in diameter, indicated by paes.) (Assist.)	pathological examination,
32102	Fee: \$654.50 Benefit: 75% =	\$490.90	
	either 3 dimensional or 2 dimensional	cm in diameter, per anal excision of, using all optic viewing systems, if removal is untion, other than a service associated with es (Anaes.) (Assist.)	nable to be performed
32103	(See para TN.8.31, TN.8.17 of explanato Fee: \$796.40 Benefit: 75% =		
	incorporating either 3 dimensional or	ater in diameter, per anal excision of, using 2 dimensional optic viewing systems, in local excision, other than a service associated applies (Anaes.) (Assist.)	f removal is unable to be
32104	(See para TN.8.31, TN.8.17 of explanato Fee: \$1,030.90 Benefit: 75% =		
	ANORECTAL CARCINOMA per a	anal full thickness excision of (Anaes.) (A	Assist.)
32105	Fee: \$499.10 Benefit: 75% =	\$374.35 85% = \$424.25	
32106		ONEAL RECTAL TUMOUR, per anal nensional or 2 dimensional optic viewing	

T8. SUF	RGICAL OPERATI	ONS	2. COLORECTAL
		ormed during colonoscopy and if removal requires a service associated with a service to which item 3 (Assist.)	
	(See para TN.8.31, Fee: \$1,407.25	TN.8.17 of explanatory notes to this Category) Benefit: 75% = \$1055.45 85% = \$1322.55	
	· ·	UR, transsphincteric excision of (Kraske or similar	operation) (Anaes.) (Assist.)
32108	Fee: \$1,030.90	Benefit: 75% = \$773.20	
	RECTAL PROL	APSE Delorme procedure for (Anaes.) (Assist.)	
32111	Fee: \$654.50	Benefit: 75% = \$490.90	
	·	APSE, perineal recto-sigmoidectomy for (Anaes.) (A	Assist.)
32112	Fee: \$796.40	Benefit: 75% = \$597.30	
32112	·	TURE, per anal release of (Anaes.)	
32114	Fee: \$179.90	Benefit: 75% = \$134.95 85% = \$152.95	
32114	·	TURE, dilatation of (Anaes.)	
32115	Fee: \$130.85	Benefit: 75% = \$98.15	
32113		APSE, abdominal rectopexy of (Anaes.) (Assist.)	
32117	Fee: \$1,030.90	Benefit: 75% = \$773.20	
		APSE, perineal repair of (Anaes.) (Assist.)	
32120	Fee: \$264.95	Benefit: 75% = \$198.75	
	ANAL STRICTU	JRE, anoplasty for (Anaes.) (Assist.)	
32123	Fee: \$343.65	Benefit: 75% = \$257.75 85% = \$292.15	
	ANAL INCONT	INENCE, Parks' intersphincteric procedure for (Ana	aes.) (Assist.)
32126	Fee: \$499.10	Benefit: 75% = \$374.35	
	ANAL SPHINC	TER, direct repair of (Anaes.) (Assist.)	
32129	Fee: \$654.50	Benefit: 75% = \$490.90	
	RECTOCELE, tr	ansanal repair of rectocele (Anaes.) (Assist.)	
32131	Fee: \$550.30	Benefit: 75% = \$412.75	
	HAEMORRHOI	DS OR RECTAL PROLAPSE sclerotherapy for (A	anaes.)
32132	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55	
		DS OR RECTAL PROLAPSE rubber band ligation fra red therapy for (Anaes.)	n of, with or without sclerotherapy,
32135	Fee: \$69.65	Benefit: 75% = \$52.25 85% = \$59.25	
	HAEMORRHOI	DECTOMY including excision of anal skin tags wh	en performed (Anaes.)
32138	Fee: \$379.25	Benefit: 75% = \$284.45 85% = \$322.40	
32139		DECTOMY involving third or fourth degree haemo	errhoids, including excision of anal

T8. SUF	RGICAL OPERAT	TIONS 2. COLORECTAL
	skin tags when p	performed (Anaes.) (Assist.)
	Fee: \$379.25	Benefit: 75% = \$284.45
		AGS or ANAL POLYPS, excision of 1 or more of (Anaes.)
32142	Fee: \$69.65	Benefit: 75% = \$52.25 85% = \$59.25
32142		AGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of
	a hospital (Anae	
32145	Fee: \$139.25	Benefit: 75% = \$104.45
	PERIANAL TH	ROMBOSIS, incision of (Anaes.)
32147	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55
	OPERATION F only (Anaes.) (A	OR FISSUREINANO, including excision or sphincterotomy, but excluding dilatation assist.)
32150	Fee: \$264.95	Benefit: 75% = \$198.75 85% = \$225.25
		ATION OF, under general anaesthesia, with or without disimpaction of faeces, not being
	a service associa	ated with a service to which another item in this Group applies (Anaes.)
32153	Fee: \$72.25	Benefit: 75% = \$54.20
	FISTULA-IN-A	NO, SUBCUTANEOUS, excision of (Anaes.)
32156	Fee: \$135.85	Benefit: 75% = \$101.90 85% = \$115.50
		A, treatment of, by excision or by insertion of a Seton, or by a combination of both olving the lower half of the anal sphincter mechanism (Anaes.) (Assist.)
32159	Fee: \$343.65	Benefit: 75% = \$257.75
		A, treatment of, by excision or by insertion of a Seton, or by a combination of both olving the upper half of the anal sphincter mechanism (Anaes.) (Assist.)
32162	Fee: \$499.10	Benefit: 75% = \$374.35
	ANAL FISTUL	A, repair of, by mucosal flap advancement (Anaes.) (Assist.)
32165	Fee: \$654.50	Benefit: 75% = \$490.90 85% = \$569.80
	ANAL FISTUL	A - readjustment of Seton (Anaes.)
32166	Fee: \$212.65	Benefit: 75% = \$159.50 85% = \$180.80
	FISTULA WOU (Anaes.)	JND, review of, under general or regional anaesthetic, as an independent procedure
32168	Fee: \$135.85	Benefit: 75% = \$101.90
		EXAMINATION, with or without biopsy, under general anaesthetic, not being a service a service to which another item in this Group applies (Anaes.)
32171	Fee: \$91.55	Benefit: 75% = \$68.70
	INTR-AANAL,	perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.)
32174	Fee: \$91.55	Benefit: 75% = \$68.70 85% = \$77.85
32175		PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating

T8. SUF	RGICAL OPERAT	IONS	2. COLORECTAL	
	theatre of a hospi	ital (excluding aftercare) (Anaes.)		
	Fee: \$167.75	Benefit: 75% = \$125.85		
	(excluding puder	removal of, under general anaesthesia, or under regional or adal block) requiring admission to a hospital, where the time to being a service associated with a service to which item 3	e taken is less than or equal	
32177	Fee: \$179.70	Benefit: 75% = \$134.80		
	(excluding puder	removal of, under general anaesthesia, or under regional or indal block) requiring admission to a hospital, where the tim ing a service associated with a service to which item 35507	e taken is greater than 45	
32180	Fee: \$264.95	Benefit: 75% = \$198.75		
	INTESTINAL S	LING PROCEDURE prior to radiotherapy (Anaes.) (Assist	t.)	
32183	Fee: \$579.20	Benefit: 75% = \$434.40		
	COLONIC LAV	AGE, total, intra operative (Anaes.) (Assist.)		
32186	Fee: \$579.20	Benefit: 75% = \$434.40		
	DISTAL MUSC	LE, devascularisation of (Anaes.) (Assist.)		
32200	Fee: \$304.95	Benefit: 75% = \$228.75 85% = \$259.25		
		INEAL GRACILOPLASTY (Anaes.) (Assist.)		
32203	Fee: \$654.85	Benefit: 75% = \$491.15		
		AND ELECTRODES, insertion of, following previous grad	ciloplasty (Anaes.) (Assist.)	
32206	Fee: \$591.65	Benefit: 75% = \$443.75		
52200		INEAL GRACILOPLASTY with insertion of stimulator and	d electrodes (Anaes.)	
32209	Fee: \$950.75	Benefit: 75% = \$713.10		
	· ·	OSPHINCTER PACEMAKER, replacement of (Anaes.)		
32210	Fee: \$263.45	Benefit: 75% = \$197.60 85% = \$223.95		
52210	ANO-RECTAL	APPLICATION OF FORMALIN in the treatment of radiat operating theatre of a hospital, excluding aftercare (Anaes.		
32212	Fee: \$140.55	Benefit: 75% = \$105.45		
		d or leads, percutaneous placement using fluoroscopic guida st stimulation, to manage faecal incontinence in a patient wl		
	a) has an anatomically intact but functionally deficient anal sphincter; and			
	b) has faecal incomonths;	ontinence that has been refractory to conservative non-surgi	ical treatment for at least 12	
	other than a patient who:			
		nfit for surgery; or		
32213	c) is inedically u	init for surgery, or		

T8. SUR	GICAL OPERATIONS	2. COLORECTAL
	d) is pregnant or planning pregnancy; or	
	e) has irritable bowel syndrome; or	
	f) has congenital anorectal malformations; or	
	g) has active anal abscesses or fistulas; or	
	h) has anorectal organic bowel disease, including cancer; or	
	i) has functional effects of previous pelvic irradiation; or	
	j) has congenital or acquired malformations of the sacrum; or	
	k) has had rectal or anal surgery within the previous 12 months (Anaes.)	
	Fee: \$681.60 Benefit: 75% = \$511.20	
	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;	atment 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.) (Assist.)	
32214	Fee: \$344.45 Benefit: 75% = \$258.35	
	Sacral nerve electrode or electrodes, management, adjustment and electronic programeurostimulator by a medical practitioner, to manage faecal incontinence, other that	C
	a) is medically unfit for surgery; or	
32215	b) is pregnant or planning pregnancy; or	

T8. SUR	GICAL OPERATIONS 2. COLORECTAL
	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
	Fee: \$129.30 Benefit: 75% = \$97.00 85% = \$109.95
	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
	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.)
32216	Fee: \$612.10 Benefit: 75% = \$459.10
	Neurostimulator or receiver, removal of, if the neurostimulator or receiver was inserted to manage faecal incontinence in a patient who:
32217	a) has an anatomically intact but functionally deficient anal sphincter; and

T8. SURGICAL OPERATIONS 2. COLORECTAL 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 i) has congenital or acquired malformations of the sacrum; or k) has had rectal or anal surgery within the previous 12 months (Anaes.) Fee: \$161.20 **Benefit:** 75% = \$120.90Sacral 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 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.)

Benefit: 75% = \$120.90

32218

Fee: \$161.20

T8. SUR	GICAL OPERATIONS	2. COLORECTAL
	Insertion of an artificial bowel sphincter for severe faecal incontinence in the treat whom conservative and other less invasive forms of treatment are contraindicated failed. Contraindicated in:	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progress diseases or a scarred or fragile perineum; and	sive degenerative
	(b) patients who have had an adverse reaction or radiopaque solution; and	
	(c) patients who enage in receptive anal intercourse (Anaes.) (Assist.)	
32220	Fee: \$932.15 Benefit: 75% = \$699.15 85% = \$847.45	
	Removal or revision of an artificial bowel sphincter (with or without replacement) incontinence in the treatment of a patient for whom conservative and other less in treatment are contraindicated or have failed. Contraindicated in:	
	(a) patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progress diseases or a scarred or fragile perineum; and	sive degenerative
	(b) patients who have had an adverse reaction to radiopaque solution; and	
	(c) patients who engage in receptive anal intercourse (Anaes.) (Assist.)	
32221	Fee: \$932.15 Benefit: 75% = \$699.15 85% = \$847.45	
	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	er; or
	(f) who is undergoing pre-operative evaluation; or	
	(g) for whom a repeat colonoscopy is required due to inadequate bowel preparation previous colonoscopy; or	n for the patient's
	(h) for the management of inflammatory bowel disease	
	Applicable only once on a day under a single episode of anaesthesia or other seda	tion (Anaes.)
32222	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10	
	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient	
	(a) who has had a colonoscopy that revealed:	
	(i) 1 to 4 adenomas, each of which was less than 10 mm in diameter, had no had no high grade dysplasia; or	villous features and
Amend 32223	(ii) 1 or 2 sessile serrated lesions, each of which was less than 10 mm in diameters.	neter, and without

T8. SUR	GICAL OPERATIONS 2. COLORECTA
	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.
	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10
	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 10 mm or greater in diameter; or
	(ii) had villous features; or
	(iii) had high grade dysplasia; or
	(b) having had a previous colonoscopy that revealed:
	(i) 5 to 9 adenomas, each of which was less than 10 mm in diameter, had no villous features and had no high grade dysplasia; or
	(ii) 1 or 2 sessile serrated lesions, each of which was 10 mm or greater in diameter or had dysplasia; or
	(iii) a hyperplastic polyp that was 10 mm or greater in diameter; or
	(iv) 3 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or
	(v) 1 or 2 traditional serrated adenomas, of any size
	Applicable only once in any 3 year period (Anaes.)
Amend 32224	(See para TN.8.152, TN.8.2, TN.8.17 of explanatory notes to this Category) Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10
	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) Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10
Amend 32226	Endoscopic examination of the colon to the caecum by colonoscopy, for a patient who has a high risk colorectal cancer due to:

T8. SUF	RGICAL OPERATIONS 2. COLORECT	ΓAL
	(a) having either:	
	(i) a known or suspected familial condition, such as familial adenomatous polyposis, Lynch syndrome or serrated polyposis syndrome; or	
	(ii) a genetic mutation associated with hereditary colorectal cancer; or	
	(b) having had a previous colonoscopy that revealed:	
	(i) 5 or more sessile serrated lesions, each of which was less than 10 mm in diameter and had no dysplasia; or)
	(ii) 3 or more sessile serrated lesions, 1 or more of which was 10 mm or greater in diameter or h dysplasia; or	ıad
	(iii) 3 or more traditional serrated adenomas, of any size	
	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) Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10	
	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 (Anaes.)	
32227	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) Fee: \$483.85 Benefit: 75% = \$362.90 85% = \$411.30	
	Endoscopic examination of the colon to the caecum by colonoscopy, other that a service to which iter 32222, 32223, 32224, 32225, or 32226 applies. Applicable only once (Anaes.)	n
32228	(See para TN.8.17, TN.8.2, TN.8.152 of explanatory notes to this Category) Fee: \$344.80 Benefit: 75% = \$258.60 85% = \$293.10	
	Removal of one or more polyps during colonoscopy, in association with a service to which item 3222 32223, 32224, 32225, 32226, or 32228 applies	2,
	(Anaes.)	
32229	(See para TN.8.152, TN.8.17, TN.8.2 of explanatory notes to this Category) Fee: \$278.10 Benefit: 75% = \$208.60 85% = \$236.40	
T8. SUF	RGICAL OPERATIONS 3. VASCUL	.AR
	Group T8. Surgical Operations	
	Subgroup 3. Vascular	

T8. SUF	RGICAL OPERATIONS 3. VASCULAR
	VARICOSE VEINS
	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding aftercare) - to a maximum of 6 treatments in a 12 month period (Anaes.)
32500	(See para TN.8.4, TN.8.32 of explanatory notes to this Category) Fee: \$113.20 Benefit: 75% = \$84.90 85% = \$96.25 Extended Medicare Safety Net Cap: \$124.55
	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507, 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.)
32504	(See para TN.8.32 of explanatory notes to this Category) Fee: \$276.05 Benefit: 75% = \$207.05 85% = \$234.65 Extended Medicare Safety Net Cap: \$220.85
	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies on the same leg (Anaes.) (Assist.)
32507	(See para TN.8.32 of explanatory notes to this Category) Fee: \$550.30 Benefit: 75% = \$412.75 85% = \$467.80 Extended Medicare Safety Net Cap: \$440.25
	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32508	(See para TN.8.32 of explanatory notes to this Category) Fee: \$550.30 Benefit: 75% = \$412.75
	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32511	(See para TN.8.32 of explanatory notes to this Category) Fee: \$818.10 Benefit: 75% = \$613.60
	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32514	(See para TN.8.32 of explanatory notes to this Category) Fee: \$955.75 Benefit: 75% = \$716.85
	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.)
32517	(See para TN.8.32 of explanatory notes to this Category) Fee: \$1,230.70 Benefit: 75% = \$923.05
	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
32520	probe introduced by an endovenous catheter, if it is documented by duplex ultrasound that the great or

T8. SURG	GICAL OPERATIONS	3. VASCULAR
	small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds of	or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or intributaries or incompetent perforating veins, or both); and	jection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate	embolisation; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32 (Anaes.)	2504 and 32507
	(See para TN.8.33 of explanatory notes to this Category) Fee: \$550.30 Benefit: 75% = \$412.75 85% = \$467.80 Extended Medicare Safety Net Cap: \$82.55	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessal probe introduced by an endovenous catheter, if it is documented by duplex ultrasound small saphenous veins demonstrate reflux of 0.5 seconds or longer:	ry), using a laser
	(a) including all preparation and immediate clinical aftercare (including excision or intributaries or incompetent perforating veins, or both); and	jection of either
	(b) not including radiofrequency diathermy, radiofrequency ablation or cyanoacrylate not provided on the same occasion as a service described in any of items 32500, 32504 (Anaes.)	
32522	(See para TN.8.33 of explanatory notes to this Category) Fee: \$818.10 Benefit: 75% = \$613.60 85% = \$733.40 Extended Medicare Safety Net Cap: \$81.85	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessa radiofrequency catheter introduced by an endovenous catheter, if it is documented by that the great or small saphenous vein (whichever is to be treated) demonstrates reflux longer:	ry), using a duplex ultrasound
	(a) including all preparation and immediate clinical aftercare (including excision or in tributaries or incompetent perforating veins, or both); and	jection of either
	(b) not including endovenous laser therapy or cyanoacrylate embolisation; and	
	(c) not provided on the same occasion as a service described in any of items 32500, 32 (Anaes.)	2504 and 32507
32523	(See para TN.8.33 of explanatory notes to this Category) Fee: \$550.30 Benefit: 75% = \$412.75 85% = \$467.80 Extended Medicare Safety Net Cap: \$82.55	
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessar adiofrequency catheter introduced by an endovenous catheter, if it is documented by that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer:	ry), using a
	(a) including all preparation and immediate clinical aftercare (including excision or intributaries or incompetent perforating veins, or both); and	jection of either
32526	(b) not including endovenous laser therapy or cyanoacrylate embolisation; and	

T8. SUF	RGICAL OPERATIONS 3. VASCULAI
	(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: \$818.10 Benefit: 75% = \$613.60 85% = \$733.40 Extended Medicare Safety Net Cap: \$81.85
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) or small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great or small saphenous vein (whichever is to be treated) demonstrates reflux of 0.5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507
	(Anaes.)
32528	(See para TN.8.33 of explanatory notes to this Category) Fee: \$550.30 Benefit: 75% = \$412.75 85% = \$467.80 Extended Medicare Safety Net Cap: \$82.55
	Varicose veins, abolition of venous reflux by occlusion of a primary or recurrent great (long) and small (short) saphenous vein of one leg (and major tributaries of saphenous veins as necessary), using cyanoacrylate adhesive, if it is documented by duplex ultrasound that the great and small saphenous veins demonstrate reflux of 0.5 seconds or longer:
	(a) including all preparation and immediate clinical aftercare (including excision or injection of either tributaries or incompetent perforating veins, or both); and
	(b) not including radiofrequency diathermy, radiofrequency ablation or endovenous laser therapy; and
	(c) not provided on the same occasion as a service described in any of items 32500, 32504 and 32507
	(Anaes.)
	(See para TN.8.33 of explanatory notes to this Category)
32529	Fee: \$818.10 Benefit: 75% = \$613.60 85% = \$733.40 Extended Medicare Safety Net Cap: \$81.85
	BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE
	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.)
32700	Fee: \$1,481.20 Benefit: 75% = \$1110.90
	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.)
32703	Fee: \$1,225.30 Benefit: 75% = \$919.00
	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.)
32708	Fee: \$1,465.75 Benefit: 75% = \$1099.35
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac

T8. SUF	RGICAL OPERATION	ONS 3. VASCULAR
	arteries (Anaes.) (Assist.)
	Fee: \$1,628.60	Benefit: 75% = \$1221.45
	AORTIC BYPAS	S for occlusive disease using a bifurcated graft with 1 or both anastomoses to the or profunda femoris arteries (Anaes.) (Assist.)
32711	Fee: \$1,791.55	Benefit: 75% = \$1343.70
	ILIO-FEMORAL	BYPASS GRAFTING (Anaes.) (Assist.)
32712	Fee: \$1,295.05	Benefit: 75% = \$971.30
	AXILLARY or SI ARTERIES (Anac	UBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL es.) (Assist.)
32715	Fee: \$1,295.05	Benefit: 75% = \$971.30
	FEMORO-FEMO	RAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)
32718	Fee: \$1,225.30	Benefit: 75% = \$919.00
	RENAL ARTERY	Y, bypass grafting to (Anaes.) (Assist.)
32721	Fee: \$1,946.30	Benefit: 75% = \$1459.75
	RENAL ARTERI	ES (both), bypass grafting to (Anaes.) (Assist.)
32724	Fee: \$2,210.05	Benefit: 75% = \$1657.55
	MESENTERIC V	ESSEL (single), bypass grafting to (Anaes.) (Assist.)
32730	Fee: \$1,675.05	Benefit: 75% = \$1256.30
	MESENTERIC V	ESSELS (multiple), bypass grafting to (Anaes.) (Assist.)
32733	Fee: \$1,946.30	Benefit: 75% = \$1459.75
	INFERIOR MESI	ENTERIC ARTERY, operation on, when performed in conjunction with another intra- ar operation (Anaes.) (Assist.)
32736	Fee: \$426.45	Benefit: 75% = \$319.85
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the phenous vein) with above knee anastomosis (Anaes.) (Assist.)
32739	Fee: \$1,333.80	Benefit: 75% = \$1000.35
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the phenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.)
32742	Fee: \$1,527.80	Benefit: 75% = \$1145.85
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the phenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal assist.)
32745	Fee: \$1,744.80	Benefit: 75% = \$1308.60
		ERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the phenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.)
32748	Fee: \$1,892.10	Benefit: 75% = \$1419.10

T8. SUF	RGICAL OPERATION	DNS	3. VASCULAR
	FEMORAL ARTI	ERY BYPASS GRAFTING using synthetic graft, with naes.) (Assist.)	lower anastomosis above or
32751	Fee: \$1,225.30	Benefit: 75% = \$919.00	
		ERY BYPASS GRAFTING, using a composite graft (sy above or below the knee, including use of a cuff or slees.) (Assist.)	
32754	Fee: \$1,527.80	Benefit: 75% = \$1145.85	
	an additional anast	ERY SEQUENTIAL BYPASS GRAFTING, (using a votomosis is made to separately revascularise more than 1 and a femoral bypass (Anaes.) (Assist.)	
32757	Fee: \$426.45	Benefit: 75% = \$319.85	
		TING OF, FROM LEG OR ARM for bypass or replacer is the subject of the bypass or graft - each vein (Anaes.	
32760	Fee: \$418.75	Benefit: 75% = \$314.10	
		ASS GRAFTING, using vein or synthetic material, not s Sub-group applies (Anaes.) (Assist.)	being a service to which
32763	Fee: \$1,225.30	Benefit: 75% = \$919.00	
		YENOUS ANASTOMOSIS, not being a service to which in independent procedure (Anaes.) (Assist.)	h another item in this Sub-
32766	Fee: \$814.35	Benefit: 75% = \$610.80	
		YENOUS ANASTOMOSIS not being a service to which en performed in combination with another vascular openes.) (Assist.)	
32769	Fee: \$282.20	Benefit: 75% = \$211.65	
		BYPASS, REPLACEMENT, LIGATION OF ANEU	RYSMS
		ING to replace a popliteal aneurysm using vein, includig saphenous vein) (Anaes.) (Assist.)	ng harvesting vein (when it is
33050	Fee: \$1,500.80	Benefit: 75% = \$1125.60	
	BYPASS GRAFT	ING to replace a popliteal aneurysm using a synthetic g	graft (Anaes.) (Assist.)
33055	Fee: \$1,203.50	Benefit: 75% = \$902.65	
	ANEURYSM IN (Anaes.) (Assist.)	THE EXTREMITIES, ligation, suture closure or excision	on of, without bypass grafting
33070	Fee: \$868.30	Benefit: 75% = \$651.25 85% = \$783.60	
	ANEURYSM IN (Assist.)	THE NECK, ligation, suture closure or excision of, with	nout bypass grafting (Anaes.)
33075	Fee: \$1,104.50	Benefit: 75% = \$828.40	
	INTRA-ABDOMI	NAL OR PELVIC ANEURYSM, ligation, suture closu	are or excision of, without
	bypass grafting (A	naes.) (Assist.)	,

T8. SUF	RGICAL OPERATIO	NS	3. VASCULAR
		COMMON OR INTERNAL CAROTID ARTERY, OR BOTH material (Anaes.) (Assist.)	H, replacement by graft
33100	Fee: \$1,481.20	Benefit: 75% = \$1110.90 85% = \$1396.50	
	THORACIC ANE	URYSM, replacement by graft (Anaes.) (Assist.)	
33103	Fee: \$2,078.25	Benefit: 75% = \$1558.70	
		OMINAL ANEURYSM, replacement by graft including re-im	plantation of arteries
33109	Fee: \$2,512.65	Benefit: 75% = \$1884.50 85% = \$2427.95	
	SUPRARENAL A of arteries (Anaes.)	BDOMINAL AORTIC ANEURYSM, replacement by graft in (Assist.)	ncluding re-implantation
33112	Fee: \$2,179.10	Benefit: 75% = \$1634.35	
		BDOMINAL AORTIC ANEURYSM, replacement by tube gracervice to which item 33116 applies (Anaes.) (Assist.)	aft, not being a service
33115	Fee: \$1,465.75	Benefit: 75% = \$1099.35	
		BDOMINAL AORTIC ANEURYSM, replacement by tube graceluding associated radiological services (Anaes.) (Assist.)	aft using endovascular
33116	Fee: \$1,442.70	Benefit: 75% = \$1082.05 85% = \$1358.00	
	arteries (with or wi	BDOMINAL AORTIC ANEURYSM, replacement by bifurcal thout excision of common iliac aneurysms) not being a service at 33119 applies (Anaes.) (Assist.)	
33118	Fee: \$1,628.60	Benefit: 75% = \$1221.45	
		BDOMINAL AORTIC ANEURYSM, replacement by bifurcate endovascular repair procedure, excluding associated radiological control of the control of	
33119	Fee: \$1,603.10	Benefit: 75% = \$1202.35 85% = \$1518.40	
		BDOMINAL AORTIC ANEURYSM, replacement by bifurcatith or without excision or bypass of common iliac aneurysms)	
33121	Fee: \$1,791.55	Benefit: 75% = \$1343.70	
	ANEURYSM OF I (Anaes.) (Assist.)	ILIAC ARTERY (common, external or internal), replacement	by graft - unilateral
33124	Fee: \$1,248.60	Benefit: 75% = \$936.45	
	ANEURYSMS OF (Anaes.) (Assist.)	FILIAC ARTERIES (common, external or internal), replacem	ent by graft - bilateral
33127	Fee: \$1,636.35	Benefit: 75% = \$1227.30 85% = \$1551.65	
	ANEURYSM OF graft (Anaes.) (Ass	VISCERAL ARTERY, excision and repair by direct anastomotist.)	osis or replacement by
33130	Fee: \$1,426.90	Benefit: 75% = \$1070.20	

T8. SUF	RGICAL OPERATI	ONS 3. VASCULAR		
	continuity (Anaes	s.) (Assist.)		
	Fee: \$1,070.05	Benefit: 75% = \$802.55		
		YSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.)		
33136	Fee: \$2,698.50	Benefit: 75% = \$2023.90		
	FALSE ANEUR	YSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.)		
33139	Fee: \$1,636.35	Benefit: 75% = \$1227.30		
	FALSE ANEUR	YSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.)		
33142	Fee: \$1,527.80	Benefit: 75% = \$1145.85 85% = \$1443.10		
	RUPTURED TH	ORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.)		
33145	Fee: \$2,628.85	Benefit: 75% = \$1971.65		
	RUPTURED THE (Assist.)	ORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)		
33148	Fee: \$3,264.70	Benefit: 75% = \$2448.55		
	RUPTURED SUI (Assist.)	PRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.)		
33151	Fee: \$3,101.90	Benefit: 75% = \$2326.45		
	RUPTURED INF (Anaes.) (Assist.)	FRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft		
33154	Fee: \$2,295.40	Benefit: 75% = \$1721.55		
		FRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.)		
33157	Fee: \$2,559.00	Benefit: 75% = \$1919.25		
		FRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft ral arteries (Anaes.) (Assist.)		
33160	Fee: \$2,559.00	Benefit: 75% = \$1919.25		
	RUPTURED ILL	AC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.)		
33163	Fee: \$2,171.50	Benefit: 75% = \$1628.65		
	RUPTURED AN (Assist.)	EURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.)		
33166	Fee: \$2,171.50	Benefit: 75% = \$1628.65 85% = \$2086.80		
	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.)			
33169	Fee: \$1,690.60	Benefit: 75% = \$1267.95		
	ANEURYSM OF	MAJOR ARTERY, replacement by graft, not being a service to which another item in oplies (Anaes.) (Assist.)		
33172	Fee: \$1,318.30	Benefit: 75% = \$988.75		

T8. SUF	RGICAL OPERATION	ONS 3. VASCULAR
	RUPTURED ANI	EURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without
	bypass grafting (A	anaes.) (Assist.)
33175	Fee: \$1,214.90	Benefit: 75% = \$911.20
	RUPTURED ANI grafting (Anaes.)	EURYSM IN THE NECK, ligation, suture closure or excision of, without bypass (Assist.)
33178	Fee: \$1,545.00	Benefit: 75% = \$1158.75
		RA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, afting (Anaes.) (Assist.)
33181	Fee: \$1,888.90	Benefit: 75% = \$1416.70
		ENDARTERECTOMY AND ARTERIAL PATCH
		TERIES OF NECK, endarterectomy of, including closure by suture (where f 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.)
33500	Fee: \$1,170.85	Benefit: 75% = \$878.15
	INNOMINATE ((Assist.)	OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.)
33506	Fee: \$1,310.60	Benefit: 75% = \$982.95
		RTERECTOMY, including closure by suture, not being a service associated with on the aorta (Anaes.) (Assist.)
33509	Fee: \$1,465.75	Benefit: 75% = \$1099.35
		ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a with a service to which item 33515 applies (Anaes.) (Assist.)
33512	Fee: \$1,628.60	Benefit: 75% = \$1221.45
	FEMORAL END	AL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-ARTERECTOMY, including closure by suture, not being a service associated with a tem 33512 applies (Anaes.) (Assist.)
33515	Fee: \$1,791.55	Benefit: 75% = \$1343.70
		ERECTOMY, including closure by suture, not being a service associated with another iliac artery (Anaes.) (Assist.)
33518	Fee: \$1,310.60	Benefit: 75% = \$982.95 85% = \$1225.90
	ILIO-FEMORAL	ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.)
33521	Fee: \$1,419.05	Benefit: 75% = \$1064.30
	·	Y, endarterectomy of (Anaes.) (Assist.)
33524	Fee: \$1,675.05	Benefit: 75% = \$1256.30
23327		ES (both), endarterectomy of (Anaes.) (Assist.)
22525		
33527	Fee: \$1,946.30	Benefit: 75% = \$1459.75 IDEDIOD MESENTEDIC ADTERY, and arterestomy of (A page) (A saigt.)
	COELIAC OR SU	JPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.)
33530	Fee: \$1,675.05	Benefit: 75% = \$1256.30

T8. SUF	RGICAL OPERATIO	NS	3. VASCULAR	
	COELIAC AND S	UPERIOR MESENTERIC ARTERY,	endarterectomy of (Anaes.) (Assist.)	
33533	Fee: \$1,946.30	Benefit: 75% = \$1459.75		
	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another item in this Sub-group applies (Anaes.) (Assist.)			
33536	Fee: \$1,388.15	Benefit: 75% = \$1041.15		
	ARTERY OF EXT	REMITIES, endarterectomy of, include	ing closure by suture (Anaes.) (Assist.)	
33539	Fee: \$1,000.35	Benefit: 75% = \$750.30		
	EXTENDED DEE (Anaes.) (Assist.)	P FEMORAL ENDARTERECTOMY	where the endarterectomy is at least 7cms long	
33542	Fee: \$1,426.90	Benefit: 75% = \$1070.20		
	ARTERY, VEIN Cless than 3cm long		by vein or synthetic material where patch is	
33545	(See para TN.8.36 of Fee: \$282.20	explanatory notes to this Category) Benefit: 75% = \$211.65		
	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.)			
33548	(See para TN.8.36 of Fee: \$574.00	explanatory notes to this Category) Benefit: 75% = \$430.50		
	VEIN, harvesting (Anaes.) (Assist.)	of from leg or arm for patch when not p	erformed through same incision as operation	
33551	(See para TN.8.36 of Fee: \$282.20	explanatory notes to this Category) Benefit: 75% = \$211.65		
		DMY, in conjunction with an arterial by site (Anaes.) (Assist.)	pass operation to prepare the site for	
33554	Fee: \$280.90	Benefit: 75% = \$210.70		
		EMBOLECTOMY, THROMBECTOMY		
	EMBOLUS, remov	val of, from artery of neck (Anaes.) (As	sist.)	
33800	Fee: \$1,217.50	Benefit: 75% = \$913.15 85% = \$1132	2.80	
	EMBOLECTOMY trunk (Anaes.) (As	-	l approach, of an artery or bypass graft of	
33803	Fee: \$1,163.30	Benefit: 75% = \$872.50		
	Embolectomy or thrombectomy (including the infusion of thrombolytic or other agents) from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery, item to be claimed once per extremity, regardless of the number of incisions required to access the artery or bypass graft (Anaes.) (Assist.)			
33806	Fee: \$837.55	Benefit: 75% = \$628.20 85% = \$752.	85	
	INFERIOR VENA (Anaes.) (Assist.)	CAVA OR ILIAC VEIN, closed thron	nbectomy by catheter via the femoral vein	
33810	Fee: \$611.00	Benefit: 75% = \$458.25 85% = \$526.	30	

T8. SUF	RGICAL OPERATIO	DNS	3. VASCULAR
	INFERIOR VENA	. CAVA OR ILIAC VEIN, open removal of thrombus or tumo	our (Anaes.) (Assist.)
33811	Fee: \$1,818.90	Benefit: 75% = \$1364.20	
	·	noval of, from femoral or other similar large vein (Anaes.) (As	ssist.)
33812	Fee: \$961.55	Benefit: 75% = \$721.20 85% = \$876.85	
33612		OR VEIN OF EXTREMITY, repair of wound of, with restor	ration of continuity, by
	lateral suture (Ana	<u> </u>	
33815	Fee: \$884.05	Benefit: 75% = \$663.05	
	MAJOR ARTERY direct anastomosis	OR VEIN OF EXTREMITY, repair of wound of, with restor (Anaes.) (Assist.)	ration of continuity, by
33818	Fee: \$1,031.40	Benefit: 75% = \$773.55	
		OR VEIN OF EXTREMITY, repair of wound of, with restor of synthetic material or vein (Anaes.) (Assist.)	ration of continuity, by
33821	Fee: \$1,178.70	Benefit: 75% = \$884.05	
	MAJOR ARTERY suture (Anaes.) (A	OR VEIN OF NECK, repair of wound of, with restoration of ssist.)	f continuity, by lateral
33824	Fee: \$1,124.40	Benefit: 75% = \$843.30	
	MAJOR ARTERY anastomosis (Anae	OR VEIN OF NECK, repair of wound of, with restoration of es.) (Assist.)	f continuity, by direct
33827	Fee: \$1,318.30	Benefit: 75% = \$988.75	
		OR VEIN OF NECK, repair of wound of, with restoration of	f continuity, by
	interposition graft	of synthetic material or vein (Anaes.) (Assist.)	
33830	Fee: \$1,512.10	Benefit: 75% = \$1134.10	
	MAJOR ARTERY lateral suture (Ana	OR VEIN OF ABDOMEN, repair of wound of, with restorates.) (Assist.)	tion of continuity by
33833	Fee: \$1,372.75	Benefit: 75% = \$1029.60	
	MAJOR ARTERY direct anastomosis	OR VEIN OF ABDOMEN, repair of wound of, with restorat (Anaes.) (Assist.)	tion of continuity by
33836	Fee: \$1,636.35	Benefit: 75% = \$1227.30	
		OR VEIN OF ABDOMEN, repair of wound of, with restoration graft (Anaes.) (Assist.)	tion of continuity by
33839	Fee: \$1,915.40	Benefit: 75% = \$1436.55	
	ARTERY OF NEO (Anaes.) (Assist.)	CK, re-operation for bleeding or thrombosis after carotid or ve	rtebral artery surgery
33842	Fee: \$946.10	Benefit: 75% = \$709.60	
		or control of post operative bleeding or thrombosis after intra to other procedure is performed (Anaes.) (Assist.)	-abdominal vascular
33845	Fee: \$659.20	Benefit: 75% = \$494.40	
33848	EXTREMITY, re-	operation on, for control of bleeding or thrombosis after vascu	lar procedure, where no

T8. SUF	RGICAL OPERATION	ONS 3. VASCULAR			
	other procedure is	performed (Anaes.) (Assist.)			
	Fee: \$659.20	Benefit: 75% = \$494.40			
	LIGA	TION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS			
		OF NECK, elective ligation or exploration of, not being a service associated with procedure (Anaes.) (Assist.)			
34100	Fee: \$729.05	Benefit: 75% = \$546.80			
	exploration of imiliac, femoral or p 32520, 32522, 325	or pulmonary artery) or great vein (superior or inferior vena cava), ligation or nediate branches or tributaries, or ligation or exploration of the subclavian, axillary, 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.)			
34103	Fee: \$426.45	Benefit: 75% = \$319.85			
	exploration of, no	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.)			
24106	Fee: \$300.80	Benefit: 75% = \$225.60 85% = \$255.70			
34106		re Safety Net Cap: \$240.65 ERY, biopsy of (Anaes.) (Assist.)			
34109	Fee: \$348.90	Benefit: 75% = \$261.70 85% = \$296.60			
	ARTERIO-VENC	US FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.)			
34112	Fee: \$884.05	Benefit: 75% = \$663.05			
	ARTERIO-VENC	US FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.)			
34115	Fee: \$1,000.35	Benefit: 75% = \$750.30			
	ARTERIO-VENC	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.)			
34118	Fee: \$1,426.90	Benefit: 75% = \$1070.20 85% = \$1342.20			
	ARTERIO-VENC continuity (Anaes	US FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of (Assist.)			
34121	Fee: \$1,139.90	Benefit: 75% = \$854.95			
	ARTERIO-VENO (Anaes.) (Assist.)	US FISTULA OF THE NECK, dissection and repair of, with restoration of continuity			
34124	Fee: \$1,248.60	Benefit: 75% = \$936.45			
	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.)				
34127	Fee: \$1,636.35	Benefit: 75% = \$1227.30			
	SURGICALLY C (Assist.)	REATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (Anaes.)			
34130	Fee: \$511.80	Benefit: 75% = \$383.85 85% = \$435.05			
34133	SCALENOTOMY	(Anaes.) (Assist.)			

T8. SUF	RGICAL OPERAT	ONS 3. VASCULAR	
	Fee: \$574.00	Benefit: 75% = \$430.50	
	FIRST RIB, rese	ction of portion of (Anaes.) (Assist.)	
34136	Fee: \$922.70	Benefit: 75% = \$692.05	
	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being service to which another item in this Sub-group applies (Anaes.) (Assist.)		
34139	Fee: \$922.70	Benefit: 75% = \$692.05	
	COELIAC ART	ERY, decompression of, for coeliac artery compression syndrome, as an independent s.) (Assist.)	
34142	Fee: \$1,139.90	Benefit: 75% = \$854.95	
		TERY, exploration of, for popliteal entrapment, with or without division of fibrous e (Anaes.) (Assist.)	
34145	Fee: \$829.75	Benefit: 75% = \$622.35	
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is 4cm or less in maximum diameter (Anaes.) (Assist.)	
34148	Fee: \$1,481.20	Benefit: 75% = \$1110.90	
		OCIATED TUMOUR, resection of, with or without repair or reconstruction of internal id arteries, when tumour is greater than 4cm in maximum diameter (Anaes.) (Assist.)	
34151	Fee: \$2,023.95	Benefit: 75% = \$1518.00	
	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.)		
34154	Fee: \$2,411.80	Benefit: 75% = \$1808.85 85% = \$2327.10	
	NECK, excision	of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.)	
34157	Fee: \$1,225.30	Benefit: 75% = \$919.00	
	AORTO-DUOD (Assist.)	ENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.)	
34160	Fee: \$2,295.40	Benefit: 75% = \$1721.55	
	AORTO-DUOD (Anaes.) (Assist.	ENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum	
34163	Fee: \$2,946.80	Benefit: 75% = \$2210.10	
		ENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and grafting (Anaes.) (Assist.)	
34166	Fee: \$2,946.80	Benefit: 75% = \$2210.10	
	INFECTED BYI (Assist.)	PASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.)	
34169	Fee: \$1,636.35	Benefit: 75% = \$1227.30	
	INFECTED AXI arteries (Anaes.)	LLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of (Assist.)	
34172	Fee: \$1,333.80	Benefit: 75% = \$1000.35	

T8. SUF	RGICAL OPERATION	ONS	3. VASCULAR
	INFECTED BYP (Anaes.) (Assist.)	ASS GRAFT FROM EXTREMITIES, excision	on of including closure of arteries
34175	Fee: \$1,225.30	Benefit: 75% = \$919.00	
0.17.0	2 000 \$1,220.00	OPERATIONS FOR VASCULAR	RACCESS
	ARTERIOVENO	US SHUNT, EXTERNAL, insertion of (Anae	
34500	Fee: \$318.05	Benefit: 75% = \$238.55 85% = \$270.35	
		US ANASTOMOSIS OF UPPER OR LOWE operation (Anaes.) (Assist.)	R LIMB, in conjunction with another
34503	Fee: \$426.45	Benefit: 75% = \$319.85	
	ARTERIOVENO	US SHUNT, EXTERNAL, removal of (Anaes	s.) (Assist.)
34506	Fee: \$217.00	Benefit: 75% = \$162.75	
		US ANASTOMOSIS OF UPPER OR LOWE arterial operation (Anaes.) (Assist.)	R LIMB, not in conjunction with
34509	Fee: \$1,008.10	Benefit: 75% = \$756.10	
	ARTERIOVENO	US ACCESS DEVICE, insertion of (Anaes.)	(Assist.)
34512	Fee: \$1,109.00	Benefit: 75% = \$831.75	
	ARTERIOVENO	US ACCESS DEVICE, thrombectomy of (An	naes.) (Assist.)
34515	Fee: \$790.95	Benefit: 75% = \$593.25	
		RTERIOVENOUS FISTULA OR PROSTHE on of (Anaes.) (Assist.)	TIC ARTERIOVENOUS ACCESS
34518	Fee: \$1,325.90	Benefit: 75% = \$994.45	
		INAL ARTERY OR VEIN, cannulation of, foing aftercare) (Anaes.) (Assist.)	or infusion chemotherapy, by open
34521	(See para TN.8.4 of Fee: \$814.65	explanatory notes to this Category) Benefit: 75% = \$611.00	
		NULATION for infusion chemotherapy by opapplies (excluding after-care) (Anaes.) (Assis	
34524	(See para TN.8.4 of Fee: \$426.45	explanatory notes to this Category) Benefit: 75% = \$319.85	
	CENTRAL VEIN access port as with	CATHETERISATION by open technique, us h central venous line catheter or other chemothaneous central vein catheterization, on a person	herapy delivery device, including any
34527	Fee: \$568.85	Benefit: 75% = \$426.65 85% = \$484.15	
	pump or access po	CATHETERISATION by percutaneous tech ort as with central venous line catheter or othe f age or over (Anaes.)	
34528	Fee: \$280.90	Benefit: 75% = \$210.70 85% = \$238.80	
34529	CENTRAL VEIN	CATHETERISATION by open technique, us th central venous line catheter or other chemoth	

associated percut	aneous central vein catheteri	zation, on a person under 10 years of age (Anaes.)
Fee: \$739.50	Benefit: 75% = \$554.65	85% = \$654.80
		HEMOTHERAPY DEVICE, removal of, by open surgical al on a person 10 years of age or over (Anaes.)
Fee: \$210.60	Benefit: 75% = \$157.95	85% = \$179.05
procedure, region	al perfusion for chemothera	cannulation of artery and vein at commencement of py, or other therapy, repair of arteriotomy and venotomy at (Anaes.) (Assist.)
Fee: \$1,279.40	Benefit: 75% = \$959.55	85% = \$1194.70
pump or access p	ort as with central venous lin	percutaneous technique, using subcutaneous tunnel with ne catheter or other chemotherapy delivery device, on a
Fee: \$365.15	Benefit: 75% = \$273.90	85% = \$310.40
		y percutaneous technique, using subcutaneous tunnelled inistration of haemodialysis or parenteral nutrition (Anaes.)
Fee: \$280.90	Benefit: 75% = \$210.70	85% = \$238.80
TUNNELLED C (Anaes.)	UFFED CATHETER, OR S	IMILAR DEVICE, removal of, by open surgical procedure
Fee: \$210.60	Benefit: 75% = \$157.95	85% = \$179.05
		HEMOTHERAPY DEVICE, removal of, by open surgical al, on a person under 10 years of age (Anaes.)
Fee: \$273.80	Benefit: 75% = \$205.35	85% = \$232.75
	COMPLEX	VENOUS OPERATIONS
INFERIOR VEN	A CAVA, plication, ligation	, or application of caval clip (Anaes.) (Assist.)
Fee: \$837.55	Benefit: 75% = \$628.20	85% = \$752.85
INFERIOR VEN	A CAVA, reconstruction of	or bypass by vein or synthetic material (Anaes.) (Assist.)
Fee: \$1,845.80	Benefit: 75% = \$1384.35	
CROSS LEG BY	PASS GRAFTING, saphene	ous to iliac or femoral vein (Anaes.) (Assist.)
Fee: \$1,000.35	Benefit: 75% = \$750.30	
· ·		moral or popliteal vein for femoral vein bypass (Anaes.)
Fee: \$1,000.35	Benefit: 75% = \$750.30	
		in bypass for, using vein or synthetic material, not being a m 34806 or 34809 applies (Anaes.) (Assist.)
Fee: \$1,209.70	Benefit: 75% = \$907.30	
	S, patch angioplasty for, (exc	cluding vein graft stenosis)-using vein or synthetic material
(See para TN.8.36	of explanatory notes to this Cat	egory)
	CENTRAL VENder procedure in the construction of procedure, region conclusion of procedure, region conclusion of procedure, region conclusion of procedure, region conclusion of procedure access properson under 10 yr Fee: \$1,279.40 CENTRAL VEIN cuffed catheter or Fee: \$280.90 TUNNELLED CONTRAL VENDER (Anaes.) Fee: \$210.60 CENTRAL VENDER (Anaes.) Fee: \$273.80 INFERIOR VENDER (Anaes.) Fee: \$1,845.80 CROSS LEG BY Fee: \$1,000.35 SAPHENOUS VIOLATION (Assist.) Fee: \$1,000.35 VENOUS STENOUS VIOLATION (Assist.) Fee: \$1,209.70 VEIN STENOSIS (Anaes.) (Assist.)	CENTRAL VENOUS LINE, OR OTHER CENTROCEDURE in the operating theatre of a hospital Fee: \$210.60 Benefit: 75% = \$157.95 ISOLATED LIMB PERFUSION, including of procedure, regional perfusion for chemotheral conclusion of procedure (excluding aftercare) Fee: \$1,279.40 Benefit: 75% = \$959.55 CENTRAL VEIN CATHETERISATION by pump or access port as with central venous lingerson under 10 years of age (Anaes.) Fee: \$365.15 Benefit: 75% = \$273.90 CENTRAL VEIN CATHERTERISATION be cuffed catheter or similar device, for the admit of the cuffed catheter or similar device, for the cuffed catheter or similar device, for the admit of the cuffed cathe

T8. SUF	RGICAL OPERATI	ONS 3. VASCULAR
	Fee: \$1,000.35	Benefit: 75% = \$750.30
	VENOUS VALV	E, plication or repair to restore valve competency (Anaes.) (Assist.)
34818	Fee: \$1,101.15	Benefit: 75% = \$825.90
	VEIN TRANSPL	ANT to restore valvular function (Anaes.) (Assist.)
34821	Fee: \$1,496.75	Benefit: 75% = \$1122.60 85% = \$1412.05
	EXTERNAL STE (Anaes.) (Assist.)	ENT, application of, to restore venous valve competency to superficial vein - 1 stent
34824	Fee: \$511.80	Benefit: 75% = \$383.85
		ENTS, application of, to restore venous valve competency to superficial vein or veins - (Anaes.) (Assist.)
34827	Fee: \$620.45	Benefit: 75% = \$465.35
	EXTERNAL STE (Assist.)	ENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.)
34830	Fee: \$729.05	Benefit: 75% = \$546.80 85% = \$644.35
	EXTERNAL STE than 1 stent) (Ana	ENTS, application of, to restore venous valve competency to deep vein or veins (more es.) (Assist.)
34833	Fee: \$946.10	Benefit: 75% = \$709.60
		SYMPATHECTOMY
	LUMBAR SYMF	PATHECTOMY (Anaes.) (Assist.)
35000	Fee: \$729.05	Benefit: 75% = \$546.80 85% = \$644.35
	CERVICAL OR (Assist.)	UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.)
35003	Fee: \$946.10	Benefit: 75% = \$709.60
		UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for ete sympathectomy by any surgical approach (Anaes.) (Assist.)
35006	Fee: \$1,186.50	Benefit: 75% = \$889.90
		PATHECTOMY, where operation is following chemical sympathectomy or for ete surgical sympathectomy (Anaes.) (Assist.)
35009	Fee: \$922.70	Benefit: 75% = \$692.05
	SACRAL or PRE	-SACRAL SYMPATHECTOMY (Anaes.) (Assist.)
35012	Fee: \$729.05	Benefit: 75% = \$546.80
		DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating tal, when debridement includes muscle, tendon or bone (Anaes.) (Assist.)
35100	Fee: \$380.05	Benefit: 75% = \$285.05
35103		MB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating tal, superficial tissue only (Anaes.)

	RGICAL OPERAT	TONS	3. VASCULAR	
	Fee: \$241.85	Benefit: 75% = \$181.40		
		MISCELLANEOUS VASCULAR	PROCEDURES	
		RTERIOGRAPHY OR VENOGRAPHY, 1 cedure on an artery or vein, 1 site (Anaes.)	or more of, performed during the course of	
35200	Fee: \$176.85	Benefit: 75% = \$132.65		
		RIES OR VEINS IN THE NECK, ABDOME N after prior surgery on these vessels (Anaes		
35202	Fee: \$842.60	Benefit: 75% = \$631.95		
		ENDOVASCULAR INTERVENTION	IAL PROCEDURES	
		AL BALLOON ANGIOPLASTY of 1 periph sure, excluding associated radiological service.)		
35300	Fee: \$531.45	Benefit: 75% = \$398.60 85% = \$451.75		
	more than 1 peri	AL BALLOON ANGIOPLASTY of aortic a pheral artery or vein of 1 limb, percutaneous vices or preparation, and excluding aftercare (s or by open exposure, excluding associated	
35303	Fee: \$681.40	Benefit: 75% = \$511.05 85% = \$596.70		
	peripheral artery	AL STENT INSERTION, 1 or more stents, is or vein of 1 limb, percutaneous or by open exaration, and excluding aftercare. (Anaes.) (As	exposure, excluding associated radiological	
35306	Fee: \$628.95	Benefit: 75% = \$471.75 85% = \$544.25		
	associated balloo	AL STENT INSERTION, 1 or more stents (non dilatation, for 1 carotid artery, percutaneous on device, in patients who:		
	- meet the indications for carotid endarterectomy; and			
	- have medical or surgical comorbidities that would make them at high risk of perioperative complications from carotid endarterectomy,			
	excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)			
35307	(See para TN.8.37 Fee: \$1,156.20	of explanatory notes to this Category) Benefit: 75% = \$867.15		
	visceral arteries	AL STENT INSERTION, 1 or more stents, i or veins, or more than 1 peripheral artery or ling associated radiological services or preparations.	vein of 1 limb, percutaneous or by open	
	Fee: \$786.15	Benefit: 75% = \$589.65 85% = \$701.45		
35309		ARTERIAL ATHERECTOMY including ass		
35309	percutaneous or	by open exposure, excluding associated radio are (Anaes.) (Assist.)	sociated balloon dilatation of 1 limb, ological services or preparation, and	
35309 35312	percutaneous or	by open exposure, excluding associated radio		

T8. SUF	RGICAL OPERATIONS 3. VASCULAR
	or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
	Fee: \$891.00 Benefit: 75% = \$668.25
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)
35317	(See para TN.8.38 of explanatory notes to this Category) Fee: \$366.90 Benefit: 75% = \$275.20 85% = \$311.90
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)
35319	Fee: \$657.70 Benefit: 75% = \$493.30 85% = \$573.00
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)
35320	Fee: \$883.45 Benefit: 75% = \$662.60 85% = \$798.75
	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids or varicose veins) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)
35321	(See para TN.8.32 of explanatory notes to this Category) Fee: \$838.70 Benefit: 75% = \$629.05 85% = \$754.00
	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
35324	Fee: \$314.50 Benefit: 75% = \$235.90
	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
35327	Fee: \$421.50 Benefit: 75% = \$316.15
	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)
35330	Fee: \$531.45 Benefit: 75% = \$398.60 85% = \$451.75
	RETRIEVAL OF INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, not including associated radiological services or preparation, and not including aftercare (Anaes.)
35331	Fee: \$611.00 Benefit: 75% = \$458.25

T8. SUF	RGICAL OPERATIONS	3. VASCULAR
	associated radiological services or preparation, and not including aftercare	
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
	Fee: \$854.05 Benefit: 75% = \$640.55	
	Retrieval of foreign body in RIGHT ATRIUM, percutaneous or by open exposure, associated radiological services or preparation, and not including aftercare	not including
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
35361	Fee: \$732.45 Benefit: 75% = \$549.35	
	Retrieval of foreign body in INFERIOR VENA CAVA or AORTA, percutaneous not including associated radiological services or preparation, and not including after	
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
35362	Fee: \$611.00 Benefit: 75% = \$458.25	
	Retrieval of foreign body in PERIPHERAL VEIN or PERIPHERAL ARTERY, per exposure, not including associated radiological services or preparation, and not including associated radiological services or preparation.	
	(foreign body does not include an instrument inserted for the purpose of a service (Anaes.) (Assist.)	being rendered)
35363	Fee: \$489.50 Benefit: 75% = \$367.15	
	INTERVENTIONAL RADIOLOGY PROCEDURES	
	DOSIMETRY, HANDLING AND INJECTION OF SIR-SPHERES for selective is therapy of hepatic metastases which are secondary to colorectal cancer and are not or ablation, used in combination with systemic chemotherapy using 5-fluorouracil not being a service to which item 35317, 35319, 35320 or 35321 applies	suitable for resection
	The procedure must be performed by a specialist or consultant physician recognise nuclear medicine or radiation oncology on an admitted patient in a hospital. To be patient's lifetime only.	
35404	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$357.45 Benefit: 75% = \$268.10	
	Trans-femoral catheterisation of the hepatic artery to administer SIR-Spheres to en microvasculature of hepatic metastases which are secondary to colorectal cancer at resection or ablation, for selective internal radiation therapy used in combination with chemotherapy using 5-fluorouracil (5FU) and leucovorin, not being a service to will 35319, 35320 or 35321 applies	nd are not suitable for vith systemic
35406		

T8. SUR	RGICAL OPERATIONS	3. VASCULAR
	excluding associated radiological services or preparation, and exclud	ing aftercare (Anaes.) (Assist.)
	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$838.70 Benefit: 75% = \$629.05	
	Catheterisation of the hepatic artery via a permanently implanted hep Spheres to embolise the microvasculature of hepatic metastases which and are not suitable for resection or ablation, for selective internal radiust systemic chemotherapy using 5-fluorouracil (5FU) and leucovor item 35317, 35319, 35320 or 35321 applies	h are secondary to colorectal cancer diation therapy used in combination
	excluding associated radiological services or preparation, and exclud	ing aftercare (Anaes.) (Assist.)
35408	(See para TN.3.1, TN.8.40 of explanatory notes to this Category) Fee: \$629.15 Benefit: 75% = \$471.90	
	UTERINE ARTERY CATHETERISATION with percutaneous admit the treatment of symptomatic uterine fibroids in a patient who has be embolisation by a specialist gynaecologist, excluding associated radio excluding aftercare (Anaes.) (Assist.)	en referred for uterine artery
35410	(See para TN.8.34 of explanatory notes to this Category) Fee: \$838.70 Benefit: 75% = \$629.05 85% = \$754.00	
	Intracranial aneurysm, ruptured or unruptured, endovascular occlusion assisted coiling if performed, with parent artery preservation, not for including aftercare, including intra-operative imaging, but in associate operative diagnostic imaging items:	use with liquid embolics only,
	- either 60009 or 60010; and	
	- either 60072, 60073, 60075, 60076, 60078 or 60079 (Anaes.) (As	ssist.)
35412	(See para TN.8.35 of explanatory notes to this Category) Fee: \$2,946.80 Benefit: 75% = \$2210.10 85% = \$2862.10	
	Mechanical thrombectomy, in a patient with a diagnosis of acute isch of a large vessel of the anterior cerebral circulation, including intra-o	
	(a) the diagnosis is confirmed by an appropriate imaging modality su magnetic resonance imaging or angiography; and	ch as computed tomography,
	(b) the service is performed by a specialist or consultant physician wirecognised by the Conjoint Committee for Recognition of Training ir and	
	(c) the service is provided in an eligible stroke centre.	
	For any particular patient - applicable once per presentation by the paregardless of the number of times mechanical thrombectomy is attem (Anaes.) (Assist.)	
35414	(See para TR.8.1 of explanatory notes to this Category) Fee: \$3,609.35 Benefit: 75% = \$2707.05	
T8. SUR	GICAL OPERATIONS	4. GYNAECOLOGICAL
	Group T8. Surgical Operations	

	RGICAL OPERAT	TIONS	4. GYNAECOLOGICAL
I		Subgrou	p 4. Gynaecological
		GICAL EXAMINATION UNDE	ER ANAESTHESIA, not being a service associated with blies (Anaes.)
35500	Fee: \$83.85	Benefit: 75% = \$62.90 85%	6 = \$71.30
	ENDOMETRIA		OF, for the control of idiopathic menorrhagia, AND ial pathology, not being a service associated with a ies (Anaes.)
35502	Fee: \$82.65	Benefit: 75% = \$62.00 85%	6 = \$70.30
			of, if the service is not associated with a service to which service mentioned in item 30062) (Anaes.)
35503	Fee: \$55.20	Benefit: 75% = \$41.40 85%	6 = \$46.95
		A, not being a service associated	E, REMOVAL OF UNDER GENERAL with a service to which another item in this Group
35506	Fee: \$55.35	Benefit: 75% = \$41.55 85%	6 = \$47.05
	nerve block (exc	cluding pudendal block) requiring 45 minutes - not being a service	under general anaesthesia, or under regional or field g admission to a hospital, where the time taken is less associated with a service to which item 32177 or 32180
35507	Fee: \$179.90	Benefit: 75% = \$134.95 85	% = \$152.95
	nerve block (exc	cluding pudendal block) requiring minutes - not being a service asso	under general anaesthesia, or under regional or field g admission to a hospital, where the time taken is ociated with a service to which item 32177 or 32180
35508	Fee: \$264.95	Benefit: 75% = \$198.75 85	
22200		Deficite. $1370 = $170.73 = 63$	% = \$225.25
33306	HYMENECTO!		% = \$225.25
35509	Fee: \$92.25		
	Fee: \$92.25	MY (Anaes.)	
	Fee: \$92.25	MY (Anaes.) Benefit: 75% = \$69.20 85%	6 = \$78.45
35509	Fee: \$92.25 BARTHOLIN'S Fee: \$228.65	MY (Anaes.) Benefit: 75% = \$69.20 85% CYST, excision of (Anaes.)	% = \$78.45 % = \$194.40
35509	Fee: \$92.25 BARTHOLIN'S Fee: \$228.65	MY (Anaes.) Benefit: 75% = \$69.20 85% 6 CYST, excision of (Anaes.) Benefit: 75% = \$171.50 85	% = \$78.45 % = \$194.40 sation of (Anaes.)
35509 35513	Fee: \$92.25 BARTHOLIN'S Fee: \$228.65 BARTHOLIN'S Fee: \$150.60 OVARIAN CYS least 2cm in diag	MY (Anaes.) Benefit: 75% = \$69.20 85% GCYST, excision of (Anaes.) Benefit: 75% = \$171.50 85 GCYST OR GLAND, marsupialis Benefit: 75% = \$112.95 85 ST ASPIRATION, for cysts of at meter in a postmenopausal person	% = \$78.45 % = \$194.40 sation of (Anaes.)
35509 35513	Fee: \$92.25 BARTHOLIN'S Fee: \$228.65 BARTHOLIN'S Fee: \$150.60 OVARIAN CYS least 2cm in diagram imaging techniq (Anaes.)	MY (Anaes.) Benefit: 75% = \$69.20 85% GCYST, excision of (Anaes.) Benefit: 75% = \$171.50 85 GCYST OR GLAND, marsupialis Benefit: 75% = \$112.95 85 ST ASPIRATION, for cysts of at meter in a postmenopausal person	% = \$78.45 % = \$194.40 sation of (Anaes.) % = \$128.05 t least 4cm in diameter in a premenopausal person and at n, by abdominal or vaginal route, using interventional ices provided for assisted reproductive techniques ry)
35509 35513 35517	Fee: \$92.25 BARTHOLIN'S Fee: \$228.65 BARTHOLIN'S Fee: \$150.60 OVARIAN CYS least 2cm in dial imaging techniq (Anaes.) (See para TN.4.11 Fee: \$214.35	Benefit: 75% = \$69.20 85% 6 CYST, excision of (Anaes.) Benefit: 75% = \$171.50 85 6 CYST OR GLAND, marsupialis Benefit: 75% = \$112.95 85 ST ASPIRATION, for cysts of at meter in a postmenopausal person ques and not associated with servi	% = \$78.45 % = \$194.40 sation of (Anaes.) % = \$128.05 t least 4cm in diameter in a premenopausal person and at n, by abdominal or vaginal route, using interventional ices provided for assisted reproductive techniques ry) % = \$182.20

T8. SUF	GICAL OPERATION	ONS		4. GYNAECOLOGICAL
	URETHRA OR U	RETHRAL CARUNCLE,	cauterisation of (Anaes.)	
35523	Fee: \$60.15	Benefit: 75% = \$45.15	85% = \$51.15	
	URETHRAL CA	RUNCLE, excision of (Anac	es.)	
35527	Fee: \$150.60	Benefit: 75% = \$112.95	85% = \$128.05	
	CLITORIS, ampu	tation of, where medically i	ndicated (Anaes.) (Assist.)	
35530	Fee: \$278.25	Benefit: 75% = \$208.70		
	Vulvoplasty or lal	pioplasty, for repair of:		
	(a) female genital	mutilation; or		
	(b) an anomaly as	sociated with a major conge	enital anomaly of the uro-gynae	ecological tract
	other than a service 43882 applies (Ar		to which item 35536, 37836, 3	7050, 37842, 37851 or
35533	(See para TN.8.123 Fee: \$360.80	of explanatory notes to this Ca Benefit: 75% = \$270.60	ategory)	
	of the specialist's	specialty, for a structural ab ium extends more than 8 cm	18 years or more, performed by normality that is causing signiful below the vaginal introitus when the capacity is a property of the capacity	icant functional impairment,
35534	(See para TN.8.123 Fee: \$360.80	of explanatory notes to this Ca Benefit: 75% = \$270.60	ategory)	
	VULVA, wide loo (Anaes.) (Assist.)	cal excision of suspected ma	alignancy or hemivulvectomy,	1 or both procedures
35536	Fee: \$359.35	Benefit: 75% = \$269.55	85% = \$305.45	
	neoplastic change		SER THERAPY for previously ra, urethra or anal canal, including	
35539	Fee: \$281.45	Benefit: 75% = \$211.10	85% = \$239.25	
	neoplastic change		SER THERAPY for previously va, urethra or anal canal, includ (Assist.)	
35542	Fee: \$329.55	Benefit: 75% = \$247.20	85% = \$280.15	
	COLPOSCOPICA by other methods		SER THERAPY for condylom	ata, unsuccessfully treated
35545	Fee: \$189.35	Benefit: 75% = \$142.05	85% = \$160.95	
	VULVECTOMY	radical, for malignancy (Ar	naes.) (Assist.)	
35548	Fee: \$860.10	Benefit: 75% = \$645.10		
		es, radical excision of, unila n) (Anaes.) (Assist.)	teral, or sentinel node dissection	on (including any pre-
35551	Fee: \$953.60	Benefit: 75% = \$715.20		

T8. SUR	GICAL OPERAT	ONS	4. GYNAECOLOGICAL
	Pelvic lymph noc chemotherapy (A	les, radical excision of, unilateral, following siminaes.) (Assist.)	lar previous dissection, radiation or
35552	Fee: \$1,434.60	Benefit: 75% = \$1075.95	
	VAGINA, DILA (Anaes.)	TATION OF, as an independent procedure include	ding any associated consultation
35554	Fee: \$44.85	Benefit: 75% = \$33.65 85% = \$38.15	
	VAGINA, remov	ral of simple tumour (including Gartner duct cyst) (Anaes.)
35557	Fee: \$221.20	Benefit: 75% = \$165.90 85% = \$188.05	
	VAGINA, partia	or complete removal of (Anaes.) (Assist.)	
35560	Fee: \$705.25	Benefit: 75% = \$528.95	
	VAGINECTOM	Y, radical, for proven invasive malignancy - 1 su	rgeon (Anaes.) (Assist.)
35561	Fee: \$1,422.55	Benefit: 75% = \$1066.95	
	VAGINECTOM	Y, radical, for proven invasive malignancy, conjure) (Anaes.) (Assist.)	oint surgery - abdominal surgeon
35562	Fee: \$1,167.95	Benefit: 75% = \$876.00	
	VAGINECTOM	Y, radical, for proven invasive malignancy, conjo	pint surgery - perineal surgeon (Assist.)
35564	Fee: \$539.15	Benefit: 75% = \$404.40	
	VAGINAL REC (Assist.)	ONSTRUCTION for congenital absence, gynatre	esia or urogenital sinus (Anaes.)
35565	Fee: \$705.25	Benefit: 75% = \$528.95	
	VAGINAL SEPT	TUM, excision of, for correction of double vagina	a (Anaes.) (Assist.)
35566	Fee: \$409.65	Benefit: 75% = \$307.25	
	SACROSPINOU (Assist.)	S COLPOPEXY FOR MANAGEMENT OF UP	PER VAGINAL PROLAPSE (Anaes.)
35568	Fee: \$644.10	Benefit: 75% = \$483.10	
	PLASTIC REPA	IR TO ENLARGE VAGINAL ORIFICE (Anaes	.)
35569	Fee: \$165.85	Benefit: 75% = \$124.40	
	Anterior vaginal	compartment repair by vaginal approach for pelv	ric organ prolapse:
	(a) involving rep	air of urethrocele and cystocele; and	
	(b) using native t	issue without graft;	
	other than a servi	ce associated with a service to which item 35573	s, 35577 or 35578 applies (Anaes.)
Amend 35570	Fee: \$571.15	Benefit: 75% = \$428.40	
Amend 35571		compartment repair by vaginal approach for pelvice	vic organ prolapse:

T8. SUR	GICAL OPERATIONS 4. GYNAECOLOGICAL
	(a) involving repair of one or more of the following:
	(i) perineum;
	(ii) rectocoele;
	(iii) enterocoele; and
	(b) using native tissue without graft;
	other than a service associated with a service to which item 35573, 35577 or 35578 applies (Anaes.) (Assist.)
	Fee: \$571.15 Benefit: 75% = \$428.40
	COLPOTOMY not being a service to which another item in this Group applies (Anaes.)
35572	Fee: \$127.70 Benefit: 75% = \$95.80
	Anterior and posterior vaginal compartment repair by vaginal approach for pelvic organ prolapse:
	(a) involving anterior and posterior compartment defects; and
	(b) using native tissue without graft;
	other than a service associated with a service to which item 35577 or 35578 applies (Anaes.) (Assist.)
Amend 35573	Fee: \$856.85 Benefit: 75% = \$642.65
	Manchester (Donald Fothergill) operation for pelvic organ prolapse, involving either or both of the following:
	(a) cervical amputation;
	(b) anterior and posterior native tissue vaginal wall repairs without graft
	(Anaes.) (Assist.)
Amend 35577	Fee: \$695.60 Benefit: 75% = \$521.70
	LE FORT OPERATION for genital prolapse, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.)
35578	Fee: \$695.60 Benefit: 75% = \$521.70
	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), less than 2cm ² in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35582 or 35585 applies
	(Anaes.) (Assist.)
Amend 35581	(See para TN.8.140 of explanatory notes to this Category) Fee: \$571.15 Benefit: 75% = \$428.40
Amend 35582	Vaginal procedure for excision of graft material in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure), 2cm ² or more in its maximum area, either singly or in multiple pieces, other than a service associated with a service to which item 35581 or 35585 applies (Anaes.) (Assist.)

T8. SUR	GICAL OPERATION	ons .	4. GYNAECOLOGICAL
	(See para TN.8.140 Fee: \$856.85	of explanatory notes to this Category) Benefit: 75% = \$642.65	
	Abdominal proced	ure, by open, laparoscopic or robot-assiste	ed approach, if the service:
	(a) is for the removal of graft material:		
	(i) in symptomatic patients with graft related complications (including graft related pain or discharge and bleeding related to graft exposure); or		
	(ii) where the graft has penetrated adjacent organs such as the bladder (including urethra) or bowe and		
	(b) if required—in bowel;	cludes retroperitoneal dissection, and mob	vilisation, of either or both of the bladder and
	other than a service	e associated with a service to which item 3	35581 or 35582 applies
	(Anaes.) (Assist.)		
Amend 35585	Fee: \$1,519.20	Benefit: 75% = \$1139.40	
	FIXATION OF TH	OR ABDOMINAL PELVIC FLOOR RE HE UTEROSACRAL AND CARDINAL I FASCIA for symptomatic upper vaginal	LIGAMENTS TO RECTOVAGINAL AND
35595	Fee: \$1,191.10	Benefit: 75% = \$893.35	
		EEN GENITAL AND URINARY OR AL item 37029, 37333 or 37336 applies (Ana	IMENTARY TRACTS, repair of, not being es.) (Assist.)
35596	Fee: \$705.25	Benefit: 75% = \$528.95	
		PEXY, laparoscopic or open procedure wheartment and to sacrum for correction of s	here graft or mesh secured to vault, anterior ymptomatic upper vaginal vault prolapse
35597	Fee: \$1,519.20	Benefit: 75% = \$1139.40	
	assess the integrity		urethral sling, with diagnostic cystoscopy to rvice associated with a service to which item
35599	Fee: \$781.55	Benefit: 75% = \$586.20	
	procedure, with or		MINOVAGINAL operation for; abdominal eing a service associated with a service to
35602	Fee: \$695.60	Benefit: 75% = \$521.70	
			MINOVAGINAL operation for; vaginal eing a service associated with a service to
35605	Fee: \$377.40	Benefit: 75% = \$283.05 85% = \$320.80	
	CERVIX, cauterist without dilatation	ation (other than by chemical means), ioni of cervix (Anaes.)	sation, diathermy or biopsy of, with or
35608	Fee: \$65.95	Benefit: 75% = \$49.50 85% = \$56.10	

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	CERVIX, removal of polyp or polypi, with or without dilatation with a service to which item 35608 applies (Anaes.)	of cervix, not being a service associated
35611	Fee: \$65.95 Benefit: 75% = \$49.50 85% = \$56.10	
	CERVIX, RESIDUAL STUMP, removal of, by abdominal appro	oach (Anaes.) (Assist.)
35612	Fee: \$521.80 Benefit: 75% = \$391.35 85% = \$443.55	
	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach	h (Anaes.) (Assist.)
35613	Fee: \$417.45 Benefit: 75% = \$313.10	
	EXAMINATION OF LOWER TRACT by a Hinselmanntype co abnormal cervical smear screen result or a history of maternal in because of suspicious signs of cancer, has been referred by anoth	gestion of oestrogen or where a patient,
35614	(See para TN.8.42 of explanatory notes to this Category) Fee: \$65.85 Benefit: 75% = \$49.40 85% = \$56.00	
	VULVA, biopsy of, when performed in conjunction with a service	ce to which item 35614 applies
35615	Fee: \$55.35 Benefit: 75% = \$41.55 85% = \$47.05	
	ENDOMETRIUM, endoscopic examination of and ablation of, be radiofrequency electrosurgery, for chronic refractory menorrhaging performed on the same day, with or without uterine curettage (A	a including any hysteroscopy
35616	Fee: \$463.65 Benefit: 75% = \$347.75	
	CERVIX, cone biopsy, amputation or repair of, other than a serv applies (Anaes.)	ice to which item 35577 or 35578
35618	Fee: \$224.80 Benefit: 75% = \$168.60 85% = \$191.10	
	ENDOMETRIAL BIOPSY where malignancy is suspected in papost menopausal bleeding (Anaes.)	tients with abnormal uterine bleeding or
35620	Fee: \$55.00 Benefit: 75% = \$41.25 85% = \$46.75	
	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy including any hysteroscopy performed on the same day, with or service associated with a service to which item 30390 applies (A	without uterine curettage, not being a
35622	Fee: \$621.30 Benefit: 75% = \$466.00	
	HYSTEROSCOPIC RESECTION of myoma, or myoma and ute performed), followed by endometrial ablation by laser or diather	
35623	Fee: \$844.85 Benefit: 75% = \$633.65	
	HYSTEROSCOPY, including biopsy, performed by a specialist where the patient is referred to him or her for the investigation of or without local anaesthetic), not being a service associated with applies	f suspected intrauterine pathology (with
35626	(See para TN.8.43 of explanatory notes to this Category) Fee: \$85.35 Benefit: 75% = \$64.05 85% = \$72.55	
35627	HYSTEROSCOPY with dilatation of the cervix performed in the being a service associated with a service to which item 35626 or	

T8. SUF	RGICAL OPERAT	IONS	4. GYNAECOLOGICAL
	Fee: \$110.50	Benefit: 75% = \$82.90	
			, performed in the operating theatre of a hospital - not being tem 35626 or 35627 applies (Anaes.)
35630	Fee: \$188.75	Benefit: 75% = \$141.60	
		ce for sterilisation) or remov	or polypectomy or tubal catheterisation (including for al of IUD which cannot be removed by other means, 1 or
35633	Fee: \$224.80	Benefit: 75% = \$168.60	85% = \$191.10
	HYSTEROSCOl diathermy (Anae		septum followed by endometrial ablation by laser or
35634	Fee: \$707.10	Benefit: 75% = \$530.35	85% = \$622.40
	HYSTEROSCO	PY involving resection of the	e uterine septum (Anaes.)
35635	Fee: \$308.80	Benefit: 75% = \$231.60	
	HYSTEROSCOI both are perform	_	yoma, or resection of myoma and uterine septum (where
35636	Fee: \$446.55	Benefit: 75% = \$334.95	
	of adhesions or s associated with a	imilar procedure - 1 or more ny other laparoscopic proce	ts, diathermy of endometriosis, ventrosuspension, division procedures with or without biopsy - not being a service dure or hysterectomy (Anaes.) (Assist.)
35637	(See para TN.1.4 c Fee: \$419.35	f explanatory notes to this Cate Benefit: 75% = \$314.55	gory)
	of the following salpingostomy, a or division of ute	procedures; oophorectomy, blation of moderate or seven ro-sacral ligaments for signi	COPY, including use of laser when required, for 1 or more ovarian cystectomy, myomectomy, salpingectomy or e endometriosis requiring more than 1 hours operating time, ficant dysmenorrhoea - not being a service associated with occdure except item 30393 (Anaes.) (Assist.)
35638	Fee: \$733.75	Benefit: 75% = \$550.35	
	miscarriage) und	er general anaesthesia, or un	nt dilatation (including curettage for incomplete der epidural or spinal (intrathecal) nerve block, including 630 applies, if performed (Anaes.)
25640	(See para TN.8.44 Fee: \$188.75	of explanatory notes to this Car Benefit: 75% = \$141.60	egory)
35640	ENDOMETRIO following proced tissue from the u than 2 cms in dia	SIS LEVEL 4 OR 5, LAPAI dures, resection of the pelvic reter, resection of the Pouch	ROSCOPIC RESECTION OF, involving any two of the side wall including dissection of endometriosis or scar of Douglas, resection of an ovarian endometrioma greater rom uterus from the level of the endocervical junction or minutes (Anaes.) (Assist.)
35641	Fee: \$1,281.50	Benefit: 75% = \$961.15	
	CURETTAGE o		THE GRAVID UTERUS BY CURETTAGE OR SUCTION item 35640 applies, including procedures to which item (Anaes.)
35643			

T8. SUF	RGICAL OPERATIONS		4. GYNAECOLOGICAL
	Fee: \$224.80 Be	enefit: 75% = \$168.60 85% = \$1	91.10
	neoplastic changes of the		y, for previously confirmed intraepithelial aesthesia and biopsies, other than a service applies (Anaes.)
35644		anatory notes to this Category) enefit: 75% = \$157.50 85% = \$1	78.50
	neoplastic changes of the ablative therapy of add	he cervix, including any local an itional areas of intraepithelial ch	by, for previously confirmed intraepithelial aesthesia and biopsies, in conjunction with ange in 1 or more sites of vagina, vulva, urethra which item 35648 applies (Anaes.)
35645		anatory notes to this Category) enefit: 75% = \$246.50 85% = \$2	79.40
		with radical diathermy of, with o al neoplastic changes of the cerv	r without cervical biopsy, for previously ix (Anaes.)
35646		anatory notes to this Category) enefit: 75% = \$157.50 85% = \$1	78.50
	intraepithelial neoplasti		gether with colposcopy for previously confirmed ng any local anaesthesia and biopsies, not being a pplies (Anaes.)
35647	_	anatory notes to this Category) enefit: 75% = \$157.50 85% = \$1	78.50
	the cervix, including an additional areas of intra	y local anaesthesia and biopsies	confirmed intraepithelial neoplastic changes of , in conjunction with ablative treatment of ites of vagina, vulva, urethra or anus, not being a pplies (Anaes.)
35648		anatory notes to this Category) enefit: 75% = \$246.50 85% = \$2	79.40
	HYSTEROTOMY or U	JTERINE MYOMECTOMY, ab	odominal (Anaes.) (Assist.)
35649	Fee: \$552.75 Bo	enefit: 75% = \$414.60	
	HYSTERECTOMY, A adnexae (Anaes.) (Assi		TOTAL, with or without removal of uterine
35653	Fee: \$695.80 Bo	enefit: 75% = \$521.85	
	HYSTERECTOMY, V 35673 applies	AGINAL, with or without utering	ne curettage, not being a service to which item
	benefits are not payabl	e for services not rendered in ac	terilisation procedures on minors. Medicare cordance with relevant Commonwealth and State e submitting a claim. (Anaes.) (Assist.)
35657		anatory notes to this Category) enefit: 75% = \$521.85	
35658	UTERUS (at least equi	valent in size to a 10 week gravi	d uterus), debulking of, prior to vaginal removal

T8. SUF	RGICAL OPERATIONS	4. GYNAECOLOGICAL
	at hysterectomy (Anaes.) (Assist.)	
	(See para TN.8.47 of explanatory notes to this Category) Fee: \$429.05 Benefit: 75% = \$321.80	
	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal di exposure of 1 or both ureters, for the management of severe endometriosis, or benign pelvic tumours, with or without conservation of the ovaries (Ana	pelvic inflammatory disease
35661	Fee: \$898.55 Benefit: 75% = \$673.95	
	RADICAL HYSTERECTOMY with radical excision of pelvic lymph node uterine adnexae) for proven malignancy including excision of any 1 or mor upper vagina or contiguous pelvic peritoneum and involving ureterolysis w (Assist.)	e of parametrium, paracolpos,
35664	Fee: \$1,497.60 Benefit: 75% = \$1123.20	
	RADICAL HYSTERECTOMY without gland dissection (with or without of for proven malignancy including excision of any 1 or more of parametrium contiguous pelvic peritoneum and involving ureterolysis where performed	, paracolpos, upper vagina or
35667	Fee: \$1,272.80 Benefit: 75% = \$954.60	
	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph nod of uterine adnexae (Anaes.) (Assist.)	es, with or without removal
35670	Fee: \$1,048.05 Benefit: 75% = \$786.05	
	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with sa or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.)	alpingectomy, oophorectomy
35673	Fee: \$781.45 Benefit: 75% = \$586.10	
	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy	ý
35674	(See para TN.4.11 of explanatory notes to this Category) Fee: \$214.35 Benefit: 75% = \$160.80 85% = \$182.20	
	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)	
35677	Fee: \$552.75 Benefit: 75% = \$414.60	
	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.)	
35678	Fee: \$666.45 Benefit: 75% = \$499.85	
33070	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.)	
25690	Fee: \$600.20 Benefit: 75% = \$450.15 85% = \$515.50	
35680	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedur	re (Anges) (Assist)
		c (1 macs.) (1 ssist.)
35684	Fee: \$485.90 Benefit: 75% = \$364.45	NUMBER ' 11 ' 1
	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIA vaginal routes or via laparoscopy using diathermy or any other method	AN TUBES, via abdominal or
35688	NOTE: Strict legal requirements apply in relation to sterilisation procedule benefits are not payable for services not rendered in accordance with relevant	

10. 301	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL
	and Territory law	v. Observe the explanatory note before	submitting a claim. (Anaes.) (Assist.)
	(See para TN 8 46	of explanatory notes to this Category)	
	Fee: \$409.65	Benefit: 75% = \$307.25	
	STERILISATION with Caesarean so		AN TUBES, when performed in conjunction
	benefits are not p		erilisation procedures on minors. Medicare cordance with relevant Commonwealth and State submitting a claim. (Anaes.) (Assist.)
35691	(See para TN.8.46 Fee: \$163.65	of explanatory notes to this Category) Benefit: 75% = \$122.75	
		(salpingostomy, salpingolysis or tubal in or more procedures (Anaes.) (Assist.)	mplantation into uterus), UNILATERAL or
35694	Fee: \$657.60	Benefit: 75% = \$493.20	
		CAL TUBOPLASTY (salpingostomy, sa or BILATERAL, 1 or more procedures (alpingolysis or tubal implantation into uterus), (Anaes.) (Assist.)
35697	Fee: \$975.75	Benefit: 75% = \$731.85	
	FALLOPIAN TU (Assist.)	JBES, unilateral microsurgical anastome	osis of, using operating microscope (Anaes.)
35700	Fee: \$752.90	Benefit: 75% = \$564.70	
		TON OF FALLOPIAN TUBES as a nor service to which another item in this Su	nrepetitive procedure not being a service ub-group applies (Anaes.)
35703	Fee: \$69.65	Benefit: 75% = \$52.25 85% = \$59.2	25
	RUBIN TEST FO	OR PATENCY OF FALLOPIAN TUBI	ES (Anaes.)
35706	Fee: \$69.65	Benefit: 75% = \$52.25 85% = \$59.2	25
33700		JBES, hydrotubation of, as a repetitive p	
2==00		, ,	. , ,
35709	Fee: \$44.85 FALLOPOSCOP (Assist.)	Benefit: 75% = \$33.65 85% = \$38.1 PY, unilateral or bilateral, including hyst	teroscopy and tubal catheterization (Anaes.)
35710	Fee: \$477.75	Benefit: 75% = \$358.35	
	LAPAROTOMY OOPHORECTO	, involving OOPHORECTOMY, SALF MY, removal of OVARIAN, PARAOV	PINGECTOMY, SALPINGO- ARIAN, FIMBRIAL or BROAD LIGAMENT ted with hysterectomy (Anaes.) (Assist.)
35713	Fee: \$467.00	Benefit: 75% = \$350.25	
	OOPHORECTO		ARIAN, FIMBRIAL or BROAD LIGAMENT
	hysterectomy (A	•	ll, other than a service associated with

T8. SUF	RGICAL OPERATI	ONS	4. GYNAECOLOGICAL
	RADICAL OR Domentectomy (A	DEBULKING OPERATION for advanced gynaechaes.) (Assist.)	cological malignancy, with or without
35720	(See para TN.8.57 Fee: \$695.60	of explanatory notes to this Category) Benefit: 75% = \$521.70	
		NEAL LYMPH NODE BIOPSIES from above the strength of gynaecological malignancy (Anaes.) (Assistant (Anaes.)	
35723	Fee: \$498.20	Benefit: 75% = \$373.65	
		MENTECTOMY with multiple peritoneal biops nalignancy (Anaes.) (Assist.)	ies for staging or restaging of
35726	Fee: \$498.20	Benefit: 75% = \$373.65	
	OVARIAN TRA malignancy (Ana	NSPOSITION out of the pelvis, in conjunction ves.)	with radical hysterectomy for invasive
35729	Fee: \$224.60	Benefit: 75% = \$168.45	
		oning for one or both ovaries to preserve ovarian on the treatment volume and dose of radiation have.)	
35730	Fee: \$224.60	Benefit: 75% = \$168.45	
	LAPAROSCOPI (Anaes.) (Assist.)	CALLY ASSISTED HYSTERECTOMY, includ	ling any associated laparoscopy
35750	Fee: \$809.10	Benefit: 75% = \$606.85	
	procedures: salp	CALLY ASSISTED HYSTERECTOMY with or ingectomy, oophorectomy, excision of ovarian cyne or both sides, including any associated laparos	yst or treatment of moderate
35753	Fee: \$894.70	Benefit: 75% = \$671.05	
	or other patholog when performed	CALLY ASSISTED HYSTERECTOMY which y, from the ureter, one or both sides, including an with one or more of the following procedures: so treatment of endometriosis, not being a service	ny associated laparoscopy, including alpingectomy, oophorectomy, excision
35754	Fee: \$1,126.00	Benefit: 75% = \$844.50	
		CALLY ASSISTED HYSTERECTOMY, when cluding any associated laparoscopy (Anaes.) (Ass	
35756	Fee: \$809.10	Benefit: 75% = \$606.85	
	under general ana	e control of POST OPERATIVE HAEMORRHA nesthesia, utilising a vaginal or abdominal and va ormed (Anaes.) (Assist.)	
35759	Fee: \$580.90	Benefit: 75% = \$435.70	
T8. SUF	RGICAL OPERATI	ons	5. UROLOGICAL
	Group T8. Surgi	cal Operations	
	Croup 10. Surgi		

T8. SUR	GICAL OPERATIONS		5. UROLOGICAL
	Si	ubgroup 5. Urological	
	Suprapubic or perineal procedure for excision symptomatic patient with graft related computed bleeding related to graft exposure), if not more provided to the patient by the same practition	lications (including graft related pre than one service to which this	pain or discharge and item applies has been
37046	Fee: \$714.05 Benefit: 75% = \$535.55		
	Prostate or prostatic bed, needle biopsy of, u obtaining 1 or more prostatic specimens.	sing prostatic magnetic resonance	e imaging techniques and
	(Anaes.)		
	(Anaes.)		
	(See para TN.8.2 of explanatory notes to this Cat-		
37226 S	Fee: \$289.65 Benefit: 75% = \$217.25		
	DEL LUC LANDONA DENECEDANA	GENERAL	1.11 . 1.74
	PELVIC LYMPHADENECTOMY, open or (Assist.)	laparoscopic, or both, unilateral	or bilateral (Anaes.)
36502	Fee: \$705.25 Benefit: 75% = \$528.95		
	RENAL TRANSPLANT (not being a service	e to which item 36506 or 36509 a	applies) (Anaes.) (Assist.)
36503	Fee: \$1,434.60 Benefit: 75% = \$1075.9	5	
	RENAL TRANSPLANT, performed by vaso anastomosis including aftercare (Anaes.) (As		ting together vascular
36506	Fee: \$953.60 Benefit: 75% = \$715.20		
	RENAL TRANSPLANT, performed by vaso together ureterovesical anastomosis including		ting
36509	Fee: \$807.45 Benefit: 75% = \$605.60		
	Nephrectomy, complete, by open, laparosco associated with a service to which item 3039		
36516	(See para TN.8.154 of explanatory notes to this C Fee: \$953.60 Benefit: 75% = \$715.20	C •	
	Nephrectomy, complete, by open, laparosco surgery on the same kidney, other than a ser applies (Anaes.) (Assist.)		
36519	(See para TN.8.154 of explanatory notes to this C Fee: \$1,331.45 Benefit: 75% = \$998.60		
	Nephrectomy, partial, by open, laparoscopic with a service to which item 30390 or 30627		than a service associated
36522	(See para TN.8.154 of explanatory notes to this C Fee: \$1,142.60 Benefit: 75% = \$856.95		
36525	Nephrectomy, partial, by open, laparoscopic	or robot-assisted approach:	

T8. SUF	RGICAL OPERATIONS	5. UROLOGICAL
	(a) if complicated by previous surgery or ablative procedure on the same kidney;	or
	(b) for a patient with a solitary functioning kidney; or	
	(c) for a patient with an estimated glomerular filtration rate (eGFR) of less than 6	50ml/min/1.73m ² ;
	other than a service associated with a service to which item 30390 or 30627 appl	ies (Anaes.) (Assist.)
	Fee: \$1,623.65 Benefit: 75% = \$1217.75	
	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or dissection of lymph nodes, with or without adrenal ectomy, for a tumour less than other than a service associated with a service to which item 30390 or 30627 appli	10 cm in diameter,
36528	(See para TN.8.154 of explanatory notes to this Category) Fee: \$1,331.45 Benefit: 75% = \$998.60	
	Nephrectomy, radical, by open, laparoscopic or robot-assisted approach, with or dissection of lymph nodes, with or without adrenalectomy:	without en bloc
	(a) for a tumour 10 cm or more in diameter; or	
	(b) if complicated by previous open or laparoscopic surgery on the same kidney;	
	other than a service associated with a service to which item 30390 or 30627 appl	ies (Anaes.) (Assist.)
36529	(See para TN.8.154 of explanatory notes to this Category) Fee: \$1,643.20 Benefit: 75% = \$1232.40	
	Nephroureterectomy, complete, by open, laparoscopic or robot-assisted approach bladder repair and any associated endoscopic procedure, other than a service assowhich item 30390 or 30627 applies (Anaes.) (Assist.)	
36531	(See para TN.8.154 of explanatory notes to this Category) Fee: \$1,194.05 Benefit: 75% = \$895.55	
	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach bloc dissection of lymph nodes, including associated bladder repair and any associated procedures, other than a service to which item 36533 applies or a service associate which item 30390 or 30627 applies (Anaes.) (Assist.)	ciated endoscopic
36532	(See para TN.8.154 of explanatory notes to this Category) Fee: \$1,713.80 Benefit: 75% = \$1285.35	
	Nephroureterectomy, for tumour, by open, laparoscopic or robot-assisted approach bloc dissection of lymph nodes, including associated bladder repair and any associated procedures, if complicated by previous open or laparoscopic surgery on the same than a service associated with a service to which item 30390 or 30627 applies (A	ciated endoscopic kidney or ureter, other
36533	(See para TN.8.154 of explanatory notes to this Category) Fee: \$2,025.55 Benefit: 75% = \$1519.20	
	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without dra exposure, not being a service to which another item in this Sub-group applies (An	
36537	Fee: \$713.00 Benefit: 75% = \$534.75	
36543	Nephrolithotomy or pyelolithotomy, or both, extended, for one or more renal stormore of nephrostomy, pyelostomy, pedicle control with or without freezing, caly	

T8. SUR	RGICAL OPERATION	DNS 5. UROLOGICA
	(Anaes.) (Assist.)	
	Fee: \$1,331.45	Benefit: 75% = \$998.60 85% = \$1246.75
		EAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment cang pretreatment consultation, unilateral (Anaes.)
36546	Fee: \$713.00	Benefit: 75% = \$534.75 85% = \$628.30
	Ureterolithotomy,	by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)
36549	Fee: \$859.15	Benefit: 75% = \$644.40
	NEPHROSTOMY	or pyelostomy, open, as an independent procedure (Anaes.) (Assist.)
36552	Fee: \$764.65	Benefit: 75% = \$573.50
	RENAL CYST O	R CYSTS, excision or unroofing of (Anaes.) (Assist.)
36558	Fee: \$670.10	Benefit: 75% = \$502.60 85% = \$585.40
	Renal biopsy, per	ormed under image guidance (closed) (Anaes.)
36561	Fee: \$177.90	Benefit: 75% = \$133.45 85% = \$151.25
		ic reconstruction of the pelvi-ureteric junction) by open, laparoscopic or robot-assist without the use of a retroperitoneal approach (Anaes.) (Assist.)
36564	Fee: \$953.60	Benefit: 75% = \$715.20
	junction obstruction	dney that is congenitally abnormal (in addition to the presence of pelvi-ureteric n), or in a solitary kidney, by open, laparoscopic or robot-assisted approach, with or a retroperitoneal approach (Anaes.) (Assist.)
36567	(See para TN.8.155 Fee: \$1,048.05	of explanatory notes to this Category) Benefit: 75% = \$786.05
		licated by previous surgery on the same kidney, by open, laparoscopic or robot- with or without the use of a retroperitoneal approach (Anaes.) (Assist.)
36570	Fee: \$1,331.45	Benefit: 75% = \$998.60
	DIVIDED URET	ER, repair of (Anaes.) (Assist.)
36573	Fee: \$953.60	Benefit: 75% = \$715.20
		and exploration of, including repair or nephrectomy, for trauma, by open, laparoscop pproach, other than a service associated with:
	(a) any other proc	dure performed on the kidney, renal pelvis or renal pedicle; or
	(b) a service to wl	ich item 30390 or 30627 applies (Anaes.) (Assist.)
36576	(See para TN.8.154 Fee: \$1,194.05	of explanatory notes to this Category) Benefit: 75% = \$895.55
	Ureterectomy, con	iplete or partial:
	(a) for a tumour w	ithin the ureter, proven by histopathology at the time of surgery; or
36579	(b) for congenital	

T8. SUF	RGICAL OPERATI	IONS 5	5. UROLOGICAL
	with or without as	ssociated bladder repair (Anaes.) (Assist.)	
	Fee: \$764.65	Benefit: 75% = \$573.50	
	URETER, transpl	lantation of, into skin (Anaes.) (Assist.)	
36585	Fee: \$764.65	Benefit: 75% = \$573.50	
	URETER, reimpl	lantation into bladder (Anaes.) (Assist.)	
36588	Fee: \$953.60	Benefit: 75% = \$715.20	
	URETER, reimpl	lantation into bladder with psoas hitch or Boari flap or both (Anaes.) ((Assist.)
36591	Fee: \$1,142.60	Benefit: 75% = \$856.95	
	, ,	lantation of, into intestine (Anaes.) (Assist.)	
36594	Fee: \$953.60	Benefit: 75% = \$715.20	
		lantation of, into another ureter (Anaes.) (Assist.)	
36597	Fee: \$953.60	Benefit: 75% = \$715.20	
		plantation of, into isolated intestinal segment, unilateral (Anaes.) (Assi	st.)
	(See para TN.8.153	3 of explanatory notes to this Category)	
36600	Fee: \$1,142.60	Benefit: 75% = \$856.95 85% = \$1057.90	
	URETERS, trans	splantation of, into isolated intestinal segment, bilateral (Anaes.) (Assi	st.)
	(See para TN.8.153	3 of explanatory notes to this Category)	
36603	Fee: \$1,331.45	Benefit: 75% = \$998.60	
		ssage of through percutaneous nephrostomy tube, using interventional ot including imaging (Anaes.)	l radiology
36604	Fee: \$276.05	Benefit: 75% = \$207.05 85% = \$234.65	
		RINARY RESERVOIR, continent, formation of, including formation nation of ureters (1 or both) into reservoir (Anaes.) (Assist.)	of nonreturn
36606	Fee: \$2,388.15	Benefit: 75% = \$1791.15	
	Ureteric stent inse	ertion of, with balloon dilatation of:	
	(a) the pelvical	lyceal system; or	
	(b) ureter; or		
	(c) the pelvicalyceal system and ureter;		
	through a nephros (Anaes.)	stomy tube using interventional radiology techniques, but not including	ng imaging
36607	Fee: \$712.30	Benefit: 75% = \$534.25	
	interventional rad	change of, percutaneously through either the ileal conduit or bladder, diology techniques, but not including imaging, not being a service assortems 36811 to 36854 apply (Anaes.)	
36608	Fee: \$276.05	Benefit: 75% = \$207.05	
	1		

T8. SUF	RGICAL OPERATION	DNS	5. UROLOGICAL
	Intestinal urinary of	conduit, reservoir or ureterostomy, revision of (Anaes	.) (Assist.)
36609	Fee: \$764.65	Benefit: 75% = \$573.50	
		conduit, incontinent, formation of (including associated ading implantation of one or both ureters into reservo	
36610	Fee: \$1,830.50	Benefit: 75% = \$1372.90	
	anastomosis), inclu	eservoir, continent, formation of (including associate ading formation of non-return valves and implantationed by open, laparoscopic or robot-assisted approach (n of one or both ureters into
36611	Fee: \$2,887.20	Benefit: 75% = \$2165.40	
	URETER, explora	tion of, with or without drainage of, as an independer	nt procedure (Anaes.) (Assist.)
36612	Fee: \$670.10	Benefit: 75% = \$502.60	
	Ureterolysis, unila	teral, with or without repositioning of the ureter, for o	obstruction of the ureter, if:
	(a) the obstruction	:	
	(i) is evident	either radiologically or by proximal ureteric dilatatio	n at operation; and
	(ii) is second	ary to retroperitoneal fibrosis; and	-
	(b) there is biopsy surgery (Anaes.) (A	proven fibrosis, endometriosis or cancer at the site of Assist.)	the obstruction at time of
36615	(See para TN.8.156 o Fee: \$764.65	of explanatory notes to this Category) Benefit: 75% = \$573.50	
	REDUCTION UR	ETEROPLASTY (Anaes.) (Assist.)	
36618	Fee: \$670.10	Benefit: 75% = \$502.60	
	CLOSURE OF CU	TANEOUS URETEROSTOMY (Anaes.) (Assist.)	
36621	Fee: \$479.05	Benefit: 75% = \$359.30	
	Nephrostomy, pero (Anaes.) (Assist.)	cutaneous, using interventional radiology techniques,	but not including imaging
36624	Fee: \$575.55	Benefit: 75% = \$431.70 85% = \$490.85	
		eutaneous, with or without any one or more of; stone of to which item 36639 or 36645 applies (Anaes.)	extraction, biopsy or diathermy,
36627	Fee: \$713.00	Benefit: 75% = \$534.75	
	and including ante	eutaneous, with incision of any one or more of; renal pagrade insertion of ureteric stent, not being a service at or 36645 applies (Anaes.) (Assist.)	
36633	Fee: \$764.65	Benefit: 75% = \$573.50 85% = \$679.95	
	and including ante	cutaneous, with incision of any one or more of; renal pagrade insertion of ureteric stent, being a service associor 36645 applies (Anaes.) (Assist.)	
36636	Fee: \$412.40	Benefit: 75% = \$309.30	
	1		

T8. SUF	RGICAL OPERATION	ONS	5. UROLOGICAL
		cutaneous, with destruction and extraction hock waves or lasers, other than a service	
36639	Fee: \$859.15	Benefit: 75% = \$644.40	
		, percutaneous, with removal or destructio 3 or more stones (Anaes.) (Assist.)	n of a stone greater than 3 cm in any
36645	Fee: \$1,099.60	Benefit: 75% = \$824.70	
	Nephrostomy drainaging (Anaes.)		nal radiology techniques, but not including
36649	Fee: \$276.05	Benefit: 75% = \$207.05 85% = \$234.65	1
		e, removal of, using interventional radiolog n stented with a double J ureteric stent and	gy techniques, but not including imaging, if that stent is left in place (Anaes.)
36650	Fee: \$154.40	Benefit: 75% = \$115.80	
	ureteric meatotom	retrograde, of one collecting system, with one, ureteric dilatation, not being a service a service (Anaes.) (Assist.)	or without any one or more of, cystoscopy, associated with a service to which item
36652	Fee: \$670.10	Benefit: 75% = \$502.60	
	1 or more of extra pelvis or calyces,	retrograde, of one collecting system, being action of stone from the renal pelvis or cally not being a service associated with a service in the same collecting system (Anaes.)	ce to which item 36656 applies to a
36654	Fee: \$859.15	Benefit: 75% = \$644.40	
	extraction of 2 or electrohydraulic of fragments, not be	more stones in the renal pelvis or calyces	elvis or calyces, with or without extraction of
36656	Fee: \$1,099.60	Benefit: 75% = \$824.70	
		OPERATIONS ON BL	ADDER
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, include catheterisation, with biopsy of bladder, not being a service associated with a service to which item 36505, 36507, 36508, 36812, 36830, 36836, 36840, 36845, 36848, 36854, 37203, 37206, 37215, 37 or 37233 applies.		ssociated with a service to which item
(Anaes.)			
36504	(See para TN.8.2 of Fee: \$304.05	explanatory notes to this Category) Benefit: 75% = \$228.05 85% = \$258.45	
36505	catheterisation, w		linate as an adjunct to white light, including lilatation, not being a service associated with lary tract except a service to which item
20202			

T8. SUF	RGICAL OPERATIONS 5. UROLOGICA
	(Anaes.)
	(See para TN.8.2 of explanatory notes to this Category) Fee: \$238.95 Benefit: 75% = \$179.25 85% = \$203.15
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36840 or 36845 applies.
	(Anaes.)
36507	(See para TN.8.2 of explanatory notes to this Category) Fee: \$400.30 Benefit: 75% = \$300.25 85% = \$340.30
	RIGID CYSTOSCOPY using blue light with hexaminolevulinate as an adjunct to white light, including catheterisation, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter, not being a service to which item 36845 applies.
	(Anaes.)
36508	(See para TN.8.2 of explanatory notes to this Category) Fee: \$780.05 Benefit: 75% = \$585.05 85% = \$695.35
	Both:
	(a) percutaneous placement of sacral nerve lead or leads using fluoroscopic guidance, or open placement of sacral nerve lead or leads; and
	(b) intra-operative 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 refractory to at least 12 months conservative non-surgical treatment
	(Anaes.)
36663	Fee: \$681.60 Benefit: 75% = \$511.20 85% = \$596.90
	Both:
	(a) percutaneous repositioning of sacral nerve lead or leads using fluoroscopic guidance, or open repositioning of sacral nerve lead or leads; and
	(b) intra-operative test stimulation, to correct displacement or unsatisfactory positioning, if inserted for the management of:
	(i) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or
	(ii) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment
36664	—other than a service to which item 36663 applies (Anaes.)

T8. SUF	RGICAL OPERAT	IONS		5. UROLOGICAL
	Fee: \$612.10	Benefit: 75% = \$459.10	85% = \$527.40	
			ement and adjustment of the period or non obstructive urinary re	
36665	Fee: \$129.30	Benefit: 75% = \$97.00	85% = \$109.95	
		subcutaneous placement of, trode or electrodes, for the		on of extension wire or wires to
	(a) detrusor over-activity that has been refractory to at least 12 months conservative non-surgical treatment; or			
	(b) non-obstructi		s been refractory to at least 12	2 months conservative
36666	Fee: \$344.45	Benefit: 75% = \$258.35	85% = \$292.80	
	Sacral nerve lead	or leads, removal of, if the	lead was inserted to manage	:
	(a) detrusor over treatment; or	-activity that has been refra	ctory to at least 12 months co	onservative non-surgical
	(b) non-obstructi		s been refractory to at least 12	2 months conservative
	(Anaes.)			
36667	Fee: \$161.20	Benefit: 75% = \$120.90	85% = \$137.05	
	Pulse generator, removal of, if the pulse generator was inserted to manage:			
	(a) detrusor over treatment; or	-activity that has been refra	ctory to at least 12 months co	onservative non-surgical
	(b) non-obstructive urinary retention that has been refractory to at least 12 months conservative non-surgical treatment			
	(Anaes.)			
36668	Fee: \$161.20	Benefit: 75% = \$120.90	85% = \$137.05	
		ial nerve stimulation, initial ologist, gynaecologist or ur		reatment of overactive bladder,
	(a) the patient ha	s been diagnosed with idiop	pathic overactive bladder; and	d
		as been refractory to, is cont ding anti-cholinergic agents	raindicated or otherwise not s;; and	suitable for conservative
	(c) the patient is therapy; and	contraindicated or otherwis	e not a suitable candidate for	botulinum toxin type A
	(d) the patient is	contraindicated or otherwis	e not a suitable candidate for	sacral nerve stimulation; and
36671	(e) the patient is	willing and able to comply	with the treatment protocol; a	and

T8. SUF	RGICAL OPERATIONS	5. UROLOGICAL
	(f) the initial treatment protocol comprises 12 sessions, delivered over a 3 month peri	od; and
	(g) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts f	For 30 minutes.
	For each patient—applicable only once, unless the patient achieves at least a 50% recoveractive bladder symptoms from baseline at any time during the 3 month treatment	
	Not applicable for a service associated with a service to which item 36672 or 36673 a	applies
	Fee: \$206.25 Benefit: 75% = \$154.70 85% = \$175.35	
	Percutaneous tibial nerve stimulation, tapering treatment protocol, for the treatment of bladder, including any associated consultation at the time the percutaneous tibial nerve treatment is administered, if:	
	(a) the patient responded to the percutaneous tibial nerve stimulation initial treatment achieved at least a 50% reduction in overactive bladder symptoms from baseline at a treatment period for the initial treatment protocol; and	
	(b) the tapering treatment protocol comprises no more than 5 sessions, delivered over and the interval between sessions is adjusted with the aim of sustaining therapeutic betreatment; and	
	(c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts f	or 30 minutes.
	Not applicable for a service associated with a service to which item 36671 or 36673 a	applies
36672	Fee: \$206.25 Benefit: 75% = \$154.70 85% = \$175.35	
	Percutaneous tibial nerve stimulation, maintenance treatment protocol, for the treatment bladder, including any associated consultation at the time the percutaneous tibial nerve treatment is administered, if:	
	(a) the patient responded to the percutaneous tibial nerve stimulation initial treatment tapering treatment protocol, and has achieved at least a 50% reduction in overactive to from baseline at any time during the treatment period for the initial treatment protocol.	oladder symptoms
	(b) the maintenance treatment protocol comprises no more than 12 sessions, delivered period, and the interval between sessions is adjusted with the aim of sustaining therap treatment; and	
	(c) each session lasts for a minimum of 45 minutes, of which neurostimulation lasts f	for 30 minutes.
	Not applicable for service associated with a service to which item 36671 or 36672 ap	plies
36673	Fee: \$206.25 Benefit: 75% = \$154.70 85% = \$175.35	
	BLADDER, catheterisation of, where no other procedure is performed (Anaes.)	
36800	Fee: \$28.45 Benefit: 75% = \$21.35 85% = \$24.20	
36803	Ureteroscopy, of one ureter, with or without any one or more of; cystoscopy, ureteric	meatotomy or

T8. SUI	RGICAL OPERATIONS	5. UROLOGICAL	
	ureteric dilatation, not being a service associated with a service to which item 36 36656, 36806, 36809, 36812, 36824 or 36848 applies (Anaes.) (Assist.)	6652, 36654,	
	(See para TN.8.51 of explanatory notes to this Category) Fee: \$480.90 Benefit: 75% = \$360.70 85% = \$408.80		
	Ureteroscopy, of one ureter:		
	(a) with or without one or more of the following:		
	(i) cystoscopy;		
	(ii) endoscopic incision of pelviureteric junction or ureteric stricture;		
	(iii) ureteric meatotomy;		
	(iv) ureteric dilatation; and		
	(b) with either or both of the following:		
	(i) extraction of stone from the ureter;		
	(ii) biopsy or diathermy of the ureter;		
	other than:		
	(c) a service associated with a service to which item 36803 or 36812 applies; or		
	(d) a service associated with a service, performed on the same ureter, to which it 36848 applies (Anaes.) (Assist.)	em 36809, 36824 or	
36806	Fee: \$670.10 Benefit: 75% = \$502.60		
	Ureteroscopy, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806, 3682 or 36848 applies to a procedure performed on the same ureter (Anaes.) (Assist.)		
36809	Fee: \$859.15 Benefit: 75% = \$644.40		
	Cystoscopy, with insertion of one or more urethral or prostatic prostheses, other with a service to which item 37203, 37207 or 37230 applies (Anaes.)	than a service associated	
36811	Fee: \$333.50 Benefit: 75% = \$250.15 85% = \$283.50		
	Either or both of cystoscopy and urethroscopy, with or without urethral dilatation associated with any other urological endoscopic procedure on the lower urinary		
36812	Fee: \$171.90 Benefit: 75% = \$128.95 85% = \$146.15		
	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts being a service associated with a service to which item 30189 applies (Anaes.)	or uretheral warts, not	
36815	(See para TN.8.9 of explanatory notes to this Category) Fee: \$245.35 Benefit: 75% = \$184.05 85% = \$208.55		
36818	Cystoscopy, with ureteric catheterisation, unilateral or bilateral, guided by fluord upper urinary tract, other than a service associated with a service to which item 3		

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICAL		
	(Anaes.)			
	Fee: \$285.25	Benefit: 75% = \$213.95 85% = \$242.50		
	Cystoscopy with one or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral (Anaes.) (Assist.)			
36821	Fee: \$333.30	Benefit: 75% = \$250.00 85% = \$283.35		
	Cystoscopy, with	ureteric catheterisation, unilateral:		
	(a) guided by fluc	proscopic imaging of the upper urinary tract; and		
	(b) including one renal pelvis;	or more of ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or of		
	other than a service (Assist.)	ce associated with a service to which item 36818, 36821 or 36830 applies (Anaes.)		
36822	Fee: \$475.95	Benefit: 75% = \$357.00 85% = \$404.60		
	Cystoscopy, with	removal of ureteric stent and ureteric catheterisation, unilateral:		
	(a) guided by fluo	(a) guided by fluoroscopic imaging of the upper urinary tract; and		
	(b) including eith	er or both of the following:		
	(i) ureteric dilatation; or			
	(ii) insertior	(ii) insertion of ureteric stent of ureter or of renal pelvis;		
	other than a servi (Anaes.) (Assist.)	ce associated with a service to which item 36818, 36821, 36830 or 36833 applies		
36823	Fee: \$547.25	Benefit: 75% = \$410.45 85% = \$465.20		
		ureteric catheterisation, unilateral or bilateral, other than a service associated with a tem 36818 applies (Anaes.)		
36824	Fee: \$219.80	Benefit: 75% = \$164.85 85% = \$186.85		
	Cystoscopy, with controlled hydrodilatation of the bladder, other than a service associated with a service to which item 37011 or 37245 applies (Anaes.)			
36827	Fee: \$237.05	Benefit: 75% = \$177.80 85% = \$201.50		
	CYSTOSCOPY,	with ureteric meatotomy (Anaes.)		
36830	Fee: \$209.60	Benefit: 75% = \$157.20		
	Cystoscopy, with removal of ureteric stent or other foreign body in the lower urinary tract, unilateral (Anaes.)			
36833	Fee: \$285.25	Benefit: 75% = \$213.95 85% = \$242.50		
		with biopsy of bladder, not being a service associated with a service to which item 840, 36845, 36848, 36854, 37203, 37206, 37215, 37230 or 37233 applies (Anaes.)		
36836	(See para TN.8.2 of Fee: \$237.05	f explanatory notes to this Category) Benefit: 75% = \$177.80 85% = \$201.50		
36840	Cystoscopy, with	diathermy, resection or visual laser destruction of bladder tumour or other lesion of the		

T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL
	bladder, for:		
	(a) a tumour or l	esion in only one quadrant of the bladder; or	
	(b) a solitary tur	nour of not more than 2 cm in diameter;	
	other than a serv	ice associated with a service to which item 36845 applies (Ana	es.)
	Fee: \$333.30	Benefit: 75% = \$250.00 85% = \$283.35	
	bladder, other th	h lavage of blood clots from bladder, including any associated of an a service associated with a service to which any of items 368 7230 and 37233 apply (Anaes.)	
36842	(See para TN.8.15 Fee: \$335.35	8 of explanatory notes to this Category) Benefit: 75% = \$251.55	
	Cystoscopy, with	h diathermy, resection or visual laser destruction of:	
	(a) multiple tum	ours in 2 or more quadrants of the bladder; or	
	(b) a solitary bla	dder tumour of more than 2 cm in diameter (Anaes.)	
36845	Fee: \$713.00	Benefit: 75% = \$534.75 85% = \$628.30	
	CYSTOSCOPY	, with resection of ureterocele (Anaes.)	
36848	Fee: \$237.05	Benefit: 75% = \$177.80	
		h injection into bladder wall, other than a service associated wit applies (H) (Anaes.)	h a service to which item
36851	Fee: \$237.05	Benefit: 75% = \$177.80	
	CYSTOSCOPY (Anaes.)	, with endoscopic incision or resection of external sphincter, bla	adder neck or both
36854	Fee: \$480.90	Benefit: 75% = \$360.70	
	ENDOSCOPIC	EXAMINATION of intestinal conduit or reservoir (Anaes.)	
36860	Fee: \$171.90	Benefit: 75% = \$128.95 85% = \$146.15	
	Litholapaxy, wit	h or without cystoscopy (Anaes.)	
36863	Fee: \$480.90	Benefit: 75% = \$360.70	
	BLADDER, par	tial excision of (Anaes.) (Assist.)	
		7 of explanatory notes to this Category)	
37000	Fee: \$764.65	Benefit: 75% = \$573.50	
		air of rupture (Anaes.) (Assist.)	
37004	Fee: \$670.10	Benefit: 75% = \$502.60	
	Open cystostomy or cystotomy, suprapubic, other than:		
	(a) a service to which item 37011 applies; or		
37008	(b) a service asso	ociated with a service to which item 37245 applies; or	

T8. SUF	RGICAL OPERATION	ONS 5. UROLOGICAL
	(c) another open b	ladder procedure (Anaes.) (Assist.)
	Fee: \$429.45	Benefit: 75% = \$322.10 85% = \$365.05
	Suprapubic stab cy (Anaes.)	ystotomy, other than a service associated with a service to which item 36827 applies
37011	(See para TN.8.159 Fee: \$96.25	of explanatory notes to this Category) Benefit: 75% = \$72.20 85% = \$81.85
	BLADDER, total	excision of (Anaes.) (Assist.)
37014	(See para TN.8.157 Fee: \$1,099.60	of explanatory notes to this Category) Benefit: 75% = \$824.70
		ision of, following previous open, laparoscopic or robot-assisted surgery, or radiation herapy to the pelvis (Anaes.) (Assist.)
37015	Fee: \$1,319.50	Benefit: 75% = \$989.65
		ding prostatectomy and pelvic lymph node dissection, other than a service associated which items 37000, 37014, 37015, 37209, 35551 or 36502 applies (Anaes.) (Assist.)
37016	Fee: \$2,057.55	Benefit: 75% = \$1543.20
	laparoscopic or ro	ding prostatectomy and pelvic lymph node dissection, following previous open, bot-assisted surgery, or radiation therapy or chemotherapy to the pelvis, other than a with a service to which items 37000, 37014, 37015, 37016, 37209, 35551 or 36502 Assist.)
37018	Fee: \$3,086.35	Benefit: 75% = \$2314.80
		ding anterior exenteration and pelvic lymph node dissection, other than a service service to which any of items 37000, 37014, 37015, 35551, 36502, and 35653 to 35756 ssist.)
37019	Fee: \$2,055.20	Benefit: 75% = \$1541.40
	BLADDER DIVE	ERTICULUM, excision or obliteration of (Anaes.) (Assist.)
37020	Fee: \$764.65	Benefit: 75% = \$573.50
	Cystectomy, including anterior exenteration and pelvic lymph node dissection, following previous oper laparoscopic or robot-assisted surgery, radiation therapy or chemotherapy to the pelvis, other than a service associated with a service to which any of items 37000, 37014, 37015, 35551, 36502 and 35653 to 35756 apply (Anaes.) (Assist.)	
37021	Fee: \$3,082.80	Benefit: 75% = \$2312.10
	VESICAL FISTU	LA, cutaneous, operation for (Anaes.)
37023	Fee: \$429.45	Benefit: 75% = \$322.10
	CUTANEOUS VI	ESICOSTOMY, establishment of (Anaes.) (Assist.)
37026	Fee: \$429.45	Benefit: 75% = \$322.10
		AL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.)
37029	Fee: \$953.60	Benefit: 75% = \$715.20
37038		INAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	DNS 5. UROLOGICAL		
	Fee: \$713.35	Benefit: 75% = \$535.05		
	Bladder stress inc (Assist.)	ontinence, sling procedure for, using a non-autologous biological sling (Anaes.)		
37039	Fee: \$695.60	Benefit: 75% = \$521.70		
	Bladder stress incontinence, sling procedure for, using a non-adjustable synthetic male sling system, other than a service associated with a service to which item 30405 or 37042 applies (Anaes.) (Assist.)			
37040	Fee: \$939.80	Benefit: 75% = \$704.85		
	BLADDER ASPIRATION by needle			
37041	Fee: \$48.05	Benefit: 75% = \$36.05 85% = \$40.85		
		ontinence, sling procedure for, using autologous fascial sling, including harvesting of service associated with a service to which item 30405 or 35599 applies (Anaes.)		
37042	Fee: \$939.80	Benefit: 75% = \$704.85		
		ontinence, Stamey or similar type needle colposuspension, other than a service service to which item 30405 or 35599 applies (Anaes.) (Assist.)		
37043	Fee: \$695.60	Benefit: 75% = \$521.70		
	Bladder stress incontinence, suprapubic procedure for, eg Burch colposuspension, other than a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.)			
37044	Fee: \$713.35	Benefit: 75% = \$535.05		
	CONTINENT C. (Assist.)	THETERISATION BLADDER STOMAS (eg. Mitrofanoff), formation of (Anaes.)		
37045	Fee: \$1,473.35	Benefit: 75% = \$1105.05		
	BLADDER ENL	ARGEMENT using intestine (Anaes.) (Assist.)		
37047	Fee: \$1,718.10	Benefit: 75% = \$1288.60		
	Bladder neck clo	ure for the management of urinary incontinence (Anaes.) (Assist.)		
37048	Fee: \$953.60	Benefit: 75% = \$715.20		
	BLADDER EXS	ROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.)		
37050	Fee: \$764.65	Benefit: 75% = \$573.50		
	·	NSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.)		
37053	Fee: \$883.45	Benefit: 75% = \$662.60		
37033	1 00 φοσο. 15	OPERATIONS ON PROSTATE		
	Prostatectomy, by open, laparoscopic or robot-assisted approach (Anaes.) (Assist.)			
37200	(See para TN.8.162 Fee: \$1,048.05	of explanatory notes to this Category) Benefit: 75% = \$786.05		
37201	without urethroso medically fit for	surethral radio-frequency needle ablation of, with or without cystoscopy and with or opy, in patients with moderate to severe lower urinary tract symptoms who are not ansurethral resection of the prostate (that is, prostatectomy using diathermy or colding services to which item 36854, 37203, 37206, 37207, 37208, 37245, 37303, 37321		

T8. SUF	RGICAL OPERATIONS 5. UROLOGICAL
	or 37324 applies (Anaes.)
	(See para TN.8.53 of explanatory notes to this Category) Fee: \$854.75 Benefit: 75% = \$641.10
	PROSTATE, transurethral radio-frequency needle ablation of, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854, 37245, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201, 37203 or 37207 which had to be discontinued for medical reasons (Anaes.)
37202	(See para TN.8.53 of explanatory notes to this Category) Fee: \$429.05 Benefit: 75% = \$321.80 85% = \$364.70
	Prostatectomy, transurethral resection using cautery, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37201, 37202, 37207, 37208, 37245, 37303, 37321 or 37324 applies (Anaes.)
37203	(See para TN.8.158 of explanatory notes to this Category) Fee: \$1,074.70 Benefit: 75% = \$806.05
	Prostatectomy, endoscopic, using diathermy or other ablative techniques:
	(a) with or without cystoscopy and with or without urethroscopy; and
	(b) including services to which one or more of items 36854, 37303, 37321 and 37324 apply;
	continuation, within 10 days, of treatment of benign prostatic hyperplasia that had to be discontinued for medical reasons (Anaes.)
37206	(See para TN.8.158 of explanatory notes to this Category) Fee: \$575.55 Benefit: 75% = \$431.70
	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854, 37201, 37202, 37203, 37206, 37245, 37303, 37321 or 37324 applies (Anaes.)
37207	Fee: \$1,074.70 Benefit: 75% = \$806.05
	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37201, 37203, 37207 or 37245 which had to be discontinued for medical reasons (Anaes.)
37208	Fee: \$575.55 Benefit: 75% = \$431.70
	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.)
37209	Fee: \$1,331.45 Benefit: 75% = \$998.60
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated) with or without bladder neck reconstruction, other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)
37210	(See para TN.8.161 of explanatory notes to this Category) Fee: \$1,643.20 Benefit: 75% = \$1232.40
37211	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate

T8. SUF	RGICAL OPERATIONS 5. UROLOGICAL
	(where clinically indicated):
	(a) with or without bladder neck reconstruction; and
	(b) with pelvic lymphadenectomy;
	other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)
	(See para TN.8.161 of explanatory notes to this Category) Fee: \$1,995.65 Benefit: 75% = \$1496.75
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated):
	(a) complicated by:
	(i) previous radiation therapy (including brachytherapy) on the prostate; or
	(ii) previous ablative procedures on the prostate; and
	(b) with bladder neck reconstruction;
	other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)
37213	(See para TN.8.161 of explanatory notes to this Category) Fee: \$2,464.65 Benefit: 75% = \$1848.50
	Prostatectomy, radical, involving total excision of the prostate, sparing of nerves around the prostate (where clinically indicated):
	(a) complicated by:
	(i) previous radiation therapy (including brachytherapy) on the prostate; or
	(ii) previous ablative procedures on the prostate; and
	(b) with bladder neck reconstruction and pelvic lymphadenectomy;
	other than a service associated with a service to which item 30390, 30627, 35551, 36502 or 37375 applies (Anaes.) (Assist.)
37214	(See para TN.8.161 of explanatory notes to this Category) Fee: \$2,993.70 Benefit: 75% = \$2245.30
	Prostate, biopsy of, endoscopic, with or without cystoscopy (Anaes.)
37215	Fee: \$429.45 Benefit: 75% = \$322.10 85% = \$365.05
	Prostate or prostatic bed, needle biopsy of, by the transrectal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55603 applies (Anaes.)
37216	(See para TN.8.160 of explanatory notes to this Category) Fee: \$144.85 Benefit: 75% = \$108.65 85% = \$123.15
37217	Prostate, implantation of radio-opaque fiducial markers into the prostate gland or prostate surgical bed, under ultrasound guidance, being an item associated with a service to which item 55603 applies (Anaes.)

T8. SUF	RGICAL OPERATIONS 5. UROLOGICAL		
	(See para TN.8.54 of explanatory notes to this Category) Fee: \$142.60 Benefit: 75% = \$106.95 85% = \$121.25		
	Prostate, injection into, one or more, excluding insertion of fiduciary markers (Anaes.)		
37218	(See para TN.8.54 of explanatory notes to this Category) Fee: \$142.60 Benefit: 75% = \$106.95 85% = \$121.25		
	Prostate or prostatic bed, needle biopsy of, by the transperineal route, using prostatic ultrasound guidance and obtaining one or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.)		
37219	(See para TN.8.160 of explanatory notes to this Category) Fee: \$347.60 Benefit: 75% = \$260.70 85% = \$295.50		
	Prostate, radioactive seed implantation of, urological component, using transrectal ultrasound guidance:		
	(a) for a patient with:		
	(i) localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable o visible by imaging) or T2 (tumour confined within prostate); and		
	(ii) a Gleason score of less than or equal to 7 (Grade Group 1 to Grade Group 3); and		
	(iii) a prostate specific antigen (PSA) of not more than 10ng/ml at the time of diagnosis; and		
	(b) performed by a urologist at an approved site in association with a radiation oncologist; and		
	(c) being a service associated with:		
	(i) services to which items 15338 and 55603 apply; and		
	(ii) a service to which item 60506 or 60509 applies (Anaes.)		
37220	(See para TN.8.55 of explanatory notes to this Category) Fee: \$1,076.80 Benefit: 75% = \$807.60		
	Prostatic abscess, endoscopic drainage of (Anaes.)		
37221	Fee: \$480.90 Benefit: 75% = \$360.70		
	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.)		
37223	Fee: \$212.70 Benefit: 75% = \$159.55		
	Prostate, diathermy or cauterisation, other than a service associated with a service to which item 37201, 37202, 37203, 37206, 37207, 37208 or 37215 applies (Anaes.)		
37224	Fee: \$333.30 Benefit: 75% = \$250.00 85% = \$283.35		
	PROSTATE, transperineal insertion of catheters into, for high dose rate brachytherapy using ultrasound guidance including any associated cystoscopy. The procedure must be performed at an approved site in association with a radiation oncologist, and be associated with a service to which item 15331 or 15332 applies. (Anaes.)		
37227	(See para TN.8.56 of explanatory notes to this Category) Fee: \$583.50 Benefit: 75% = \$437.65 85% = \$498.80		
37230	Prostate, ablation by electrocautery or high-energy transurethral microwave thermotherapy, with or without cystoscopy and with or without urethroscopy (Anaes.)		

T8. SUF	RGICAL OPERATI	ons	5. UROLOGICAL
	(See para TN.8.163 Fee: \$1,074.70	of explanatory notes to this Category) Benefit: 75% = \$806.05 85% = \$990.00	
	without cystoscop	by electrocautery or high-energy transurethral microwave by and with or without urethroscopy, continuation, within prostate that had to be discontinued for medical reasons (A	10 days, of a urological
37233	(See para TN.8.163 Fee: \$575.55	of explanatory notes to this Category) Benefit: 75% = \$431.70 85% = \$490.85	
	Prostate, endosco	pic enucleation of, for the treatment of benign prostatic hy	yperplasia:
	(a) with morcellat	cion, including mechanical morcellation or by an endosco	pic technique; and
	(b) with or withou	at cystoscopy; and	
	(c) with or withou	at urethroscopy; and	
		ce associated with a service to which item 36827, 36854, 208, 37303, 37321 or 37324 applies (Anaes.)	37008, 37201, 37202, 37203,
37245	Fee: \$1,301.60	Benefit: 75% = \$976.20	
		OPERATIONS ON URETHRA, PENIS OR SCRO	TUM
	URETHRAL SO	UNDS, passage of, as an independent procedure (Anaes.)	
37300	Fee: \$48.05	Benefit: 75% = \$36.05 85% = \$40.85	
	URETHRAL STE	RICTURE, dilatation of (Anaes.)	
37303	Fee: \$76.40	Benefit: 75% = \$57.30 85% = \$64.95	
	URETHRA, repa	ir of rupture of distal section (Anaes.) (Assist.)	
37306	Fee: \$670.10	Benefit: 75% = \$502.60	
	URETHRA, repa	ir of rupture of prostatic or membranous segment (Anaes.) (Assist.)
37309	Fee: \$953.60	Benefit: 75% = \$715.20	
		th or without cystoscopy, with one or more of biopsy, dia thral calculi or removal of foreign body or calculi (Anaes	
37318	Fee: \$285.25	Benefit: 75% = \$213.95 85% = \$242.50	
	URETHRAL ME	ATOTOMY, EXTERNAL (Anaes.)	
37321	Fee: \$96.25	Benefit: 75% = \$72.20 85% = \$81.85	
	Urethrotomy or u	rethrostomy, internal or external (Anaes.) (Assist.)	
37324	Fee: \$237.05	Benefit: 75% = \$177.80	
	URETHROTOM	Y, optical, for urethral stricture (Anaes.) (Assist.)	
37327	Fee: \$333.30	Benefit: 75% = \$250.00	
	URETHRECTON	MY, partial or complete, for removal of tumour (Anaes.) (Assist.)
37330	Fee: \$670.10	Benefit: 75% = \$502.60	
37333	URETHROVAG	INAL FISTULA, closure of (Anaes.) (Assist.)	

T8. SUF	RGICAL OPERAT	IONS 5.	UROLOGICAL
	Fee: \$575.55	Benefit: 75% = \$431.70	
	URETHROREC	TAL FISTULA, closure of (Anaes.) (Assist.)	
37336	Fee: \$764.65	Benefit: 75% = \$573.50	
	or infection, follo	ic male sling system, division or removal of, for urethral obstruction, sline owing previous surgery for urinary incontinence, other than a service as item 37340 or 37341 applies (Anaes.) (Assist.)	
37338	Fee: \$939.80	Benefit: 75% = \$704.85	
	incontinence, inc	ansurethral injection of urethral bulking agents for the treatment of uring cluding cystoscopy and urethroscopy, other than a service associated with 5 or 18379 applies (Anaes.)	
37339	Fee: \$247.35	Benefit: 75% = \$185.55 85% = \$210.25	
	following previo	ce sling, division or removal of, for urethral obstruction, sling erosion, pour surgery for urinary incontinence, vaginal approach, other than a serve which item 37341 or 37344 applies (Anaes.) (Assist.)	
37340	Fee: \$939.80	Benefit: 75% = \$704.85	
	previous surgery suprapubic and p 37344 applies (A		l or combined
37341	Fee: \$939.80	Benefit: 75% = \$704.85	
	URETHROPLA	STY single stage operation (Anaes.) (Assist.)	
37342	Fee: \$859.15	Benefit: 75% = \$644.40	
	below the symph	STY, single stage operation, transpubic approach via separate incisions aysis pubis, excluding laparotomy, symphysectomy and suprapubic cyst ag of the urethra around the crura (Anaes.) (Assist.)	
37343	Fee: \$1,434.60	Benefit: 75% = \$1075.95	
	obstruction, sling	ous fascial sling (or other biological sling), division or removal of, for ug erosion, pain or infection following previous surgery for urinary incomban a service to which 37340 or 37341 applies (Anaes.) (Assist.)	
37344	Fee: \$939.80	Benefit: 75% = \$704.85	
	URETHROPLA	STY 2 stage operation first stage (Anaes.) (Assist.)	
37345	Fee: \$713.00	Benefit: 75% = \$534.75	
	<u> </u>	STY 2 stage operation second stage (Anaes.) (Assist.)	
37348	Fee: \$713.00	Benefit: 75% = \$534.75	
	· · · · · · · · · · · · · · · · · · ·	STY, not being a service to which another item in this Group applies (A	naes.) (Assist.)
37351	Fee: \$285.25	Benefit: 75% = \$213.95	,
31331		S, meatotomy and hemicircumcision (Anaes.) (Assist.)	
25254			
37354	Fee: \$333.30	Benefit: 75% = \$250.00	

T8. SUF	RGICAL OPERATI	ONS 5. UROLOGICA
	URETHRA, exci	sion of prolapse of (Anaes.)
37369	Fee: \$192.45	Benefit: 75% = \$144.35
		llum, excision of (Anaes.) (Assist.)
37372	Fee: \$953.60	Benefit: 75% = \$715.20
37372		HINCTER, reconstruction by bladder tubularisation technique or similar procedure
27275		
37375	Fee: \$1,194.05	Benefit: 75% = \$895.55 ZINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.)
	ARTIFICIAL UF	INARY SPHINCTER, insertion of cult, perinear approach (Anaes.) (Assist.)
37381	Fee: \$764.65	Benefit: 75% = \$573.50
	ARTIFICIAL UF	INARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.)
37384	Fee: \$1,194.05	Benefit: 75% = \$895.55
	ARTIFICIAL UF (Assist.)	INARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.)
37387	Fee: \$333.30	Benefit: 75% = \$250.00
	Artificial urinary	sphincter, sterile, percutaneous adjustment of filling volume
37388	Fee: \$101.00	Benefit: 75% = \$75.75 85% = \$85.85
	ARTIFICIAL UF (Assist.)	INARY SPHINCTER, revision or removal of, with or without replacement (Anaes.)
37390	Fee: \$953.60	Benefit: 75% = \$715.20
	PRIAPISM, deco	mpression by glanular stab cavernosospongiosum shunt or penile aspiration with or anaes.)
37393	Fee: \$237.05	Benefit: 75% = \$177.80 85% = \$201.50
	PRIAPISM, shun	t operation for, not being a service to which item 37393 applies (Anaes.) (Assist.)
37396	Fee: \$764.65	Benefit: 75% = \$573.50
		exputation of (Anaes.) (Assist.)
37402	Fee: \$480.90	Benefit: 75% = \$360.70
37402		or radical amputation of (Anaes.) (Assist.)
27.405		
37405	Fee: \$953.60 PENIS repair of	Benefit: 75% = \$715.20 laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.)
		·
37408	Fee: \$480.90	Benefit: 75% = \$360.70
	PENIS, repair of	avulsion (Anaes.) (Assist.)
37411	Fee: \$953.60	Benefit: 75% = \$715.20 85% = \$868.90
	Penis, injection o twice in a 36-more	f, for the investigation and treatment of erectile dysfunction. Applicable not more than
37415	twice in a 50 mor	m porton

T8. SUF	RGICAL OPERAT	IONS	5. UROLOGICAL	
	Fee: \$48.05	Benefit: 75% = \$36.05 85% = \$40.85		
	Penis, correction	of chordee by plication techniques including N	Jesbit's corporoplasty (Anaes.) (Assist.)	
37417	Fee: \$575.55	Benefit: 75% = \$431.70		
	Penis, correction of chordee with incision or excision of fibrous plaque or plaques, with or without mobilisation of one or both of the neuro-vascular bundle and urethra (Anaes.) (Assist.)			
37418	Fee: \$764.65	Benefit: 75% = \$573.50 85% = \$679.95		
		ng by translocation of corpora, in conjunction w dary repair, either as primary or secondary prod		
37423	(See para TN.8.16 Fee: \$953.60	4 of explanatory notes to this Category) Benefit: 75% = \$715.20		
	PENIS, artificial	erection device, insertion of, into 1 or both cor	pora (Anaes.) (Assist.)	
37426	Fee: \$1,005.00	Benefit: 75% = \$753.75		
	PENIS, artificial	erection device, insertion of pump and pressure	e regulating reservoir (Anaes.) (Assist.)	
37429	Fee: \$333.30	Benefit: 75% = \$250.00		
	PENIS, artificial replacement (An	erection device, complete or partial revision or aes.) (Assist.)	removal of components, with or without	
37432	Fee: \$953.60	Benefit: 75% = \$715.20		
	PENIS, frenulop	lasty as an independent procedure (Anaes.)		
37435	Fee: \$96.25	Benefit: 75% = \$72.20 85% = \$81.85		
	Scrotum, partial	excision of, for histologically proven malignan	cy or infection (Anaes.) (Assist.)	
37438	Fee: \$285.25 Benefit: 75% = \$213.95 85% = \$242.50			
		OPERATIONS ON TESTES, VASA OR SI	EMINAL VESICLES	
	SPERMATOCE	LE OR EPIDIDYMAL CYST, excision of, 1 or	r more of, on 1 side (Anaes.)	
37601	Fee: \$285.25	Benefit: 75% = \$213.95 85% = \$242.50		
		crotal contents, with or without fixation and with an a service associated with sperm harvesting to		
37604	Fee: \$285.25	Benefit: 75% = \$213.95 85% = \$242.50		
		sperm retrieval, unilateral, from either the testis mic sperm injection, for male factor infertility,		
37605	(See para TN.8.58 Fee: \$385.15	TN.1.5 of explanatory notes to this Category) Benefit: 75% = \$288.90 85% = \$327.40		
	biopsy, for the p	erm retrieval, unilateral, including the explorate urposes of intracytoplasmic sperm injection, for ng a service to which item 13218 or 37604 app	r male factor infertility, performed in a	
37606	(See para TN.1.5, Fee: \$571.85	TN.8.59 of explanatory notes to this Category) Benefit: 75% = \$428.90 85% = \$487.15		
37607		ritoneal lymph node dissection, for testicular tu	mour, other than a service associated	

	RGICAL OPERATIONS	5. UROLOGICAL
	with a service to which item 30390 or 30627 applies	s (Anaes.) (Assist.)
	(See para TN.8.165 of explanatory notes to this Category) Fee: \$1,430.40 Benefit: 75% = \$1072.80	
	Bilateral retroperitoneal lymph node dissection, for retroperitoneal dissection, retroperitoneal radiation t associated with a service to which item 30390 or 300 cm.	herapy or chemotherapy, other than a service
37610	(See para TN.8.165 of explanatory notes to this Category) Fee: \$2,151.95 Benefit: 75% = \$1614.00	
	EPIDIDYMECTOMY (Anaes.)	
37613	Fee: \$285.25 Benefit: 75% = \$213.95 85% =	= \$242.50
	VASOVASOSTOMY or VASOEPIDIDYMOSTOM being a service associated with sperm harvesting for	
37616	Fee: \$713.00 Benefit: 75% = \$534.75	
	VASOVASOSTOMY or VASOEPIDIDYMOSTOM sperm harvesting for IVF (Anaes.) (Assist.)	MY, unilateral, not being a service associated with
37619	Fee: \$285.25 Benefit: 75% = \$213.95 85% = Extended Medicare Safety Net Cap: \$228.20	= \$242.50
	VASOTOMY OR VASECTOMY, unilateral or bila	itet at
	NOTE: Strict legal requirements apply in relation t	o sterilisation procedures on minors. Medicare
		accordance with relevant Commonwealth and State
37623	benefits are not payable for services not rendered in	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.)
37623	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 85% = PAEDIATRIC GENIT	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$\frac{201.50}{201.00}\$ URINARY SURGERY
37623	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 85% =	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$\frac{201.50}{201.00}\$ URINARY SURGERY
37623 37800	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 85% = PAEDIATRIC GENIT	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$\frac{201.50}{201.00}\$ URINARY SURGERY
	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 PAEDIATRIC GENIT PATENT URACHUS, excision of, on a person 10 y Fee: \$537.55 Benefit: 75% = \$403.20	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$\frac{201.50}{201.00}\$ URINARY SURGERY
	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 PAEDIATRIC GENIT PATENT URACHUS, excision of, on a person 10 y Fee: \$537.55 Benefit: 75% = \$403.20	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$201.50 URINARY SURGERY ears of age or over. (Anaes.) (Assist.)
37800	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 PAEDIATRIC GENIT PATENT URACHUS, excision of, on a person 10 y Fee: \$537.55 Benefit: 75% = \$403.20 PATENT URACHUS, excision of, when performed	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$201.50 URINARY SURGERY ears of age or over. (Anaes.) (Assist.) on a person under 10 years of age (Anaes.) (Assist.)
37800	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 PATENT URACHUS, excision of, on a person 10 y Fee: \$537.55 Benefit: 75% = \$403.20 PATENT URACHUS, excision of, when performed Fee: \$698.85 Benefit: 75% = \$524.15 UNDESCENDED TESTIS, orchidopexy for, not be	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$201.50 URINARY SURGERY ears of age or over. (Anaes.) (Assist.) on a person under 10 years of age (Anaes.) (Assist.)
37800 37801	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 PAEDIATRIC GENIT PATENT URACHUS, excision of, on a person 10 y Fee: \$537.55 Benefit: 75% = \$403.20 PATENT URACHUS, excision of, when performed Fee: \$698.85 Benefit: 75% = \$524.15 UNDESCENDED TESTIS, orchidopexy for, not be person 10 years of age or over. (Anaes.) (Assist.)	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$201.50 URINARY SURGERY ears of age or over. (Anaes.) (Assist.) on a person under 10 years of age (Anaes.) (Assist.) ing a service to which item 37806 applies, on a
37800 37801	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 PAEDIATRIC GENIT PATENT URACHUS, excision of, on a person 10 y Fee: \$537.55 Benefit: 75% = \$403.20 PATENT URACHUS, excision of, when performed Fee: \$698.85 Benefit: 75% = \$524.15 UNDESCENDED TESTIS, orchidopexy for, not be person 10 years of age or over. (Anaes.) (Assist.) Fee: \$537.55 Benefit: 75% = \$403.20 UNDESCENDED TESTIS, orchidopexy for, not be	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$\frac{2}{2}\$\$ \$201.50 URINARY SURGERY ears of age or over. (Anaes.) (Assist.) on a person under 10 years of age (Anaes.) (Assist.) ing a service to which item 37806 applies, on a
37800 37801 37803	benefits are not payable for services not rendered in and Territory law. Observe the explanatory note be (See para TN.8.46 of explanatory notes to this Category) Fee: \$237.05 Benefit: 75% = \$177.80 PAEDIATRIC GENIT PATENT URACHUS, excision of, on a person 10 y Fee: \$537.55 Benefit: 75% = \$403.20 PATENT URACHUS, excision of, when performed Fee: \$698.85 Benefit: 75% = \$524.15 UNDESCENDED TESTIS, orchidopexy for, not be person 10 years of age or over. (Anaes.) (Assist.) Fee: \$537.55 Benefit: 75% = \$403.20 UNDESCENDED TESTIS, orchidopexy for, not be person under 10 years of age (Anaes.) (Assist.)	accordance with relevant Commonwealth and State fore submitting a claim. (Anaes.) \$\frac{201.50}{URINARY SURGERY}\$ ears of age or over. (Anaes.) (Assist.) on a person under 10 years of age (Anaes.) (Assist.) ing a service to which item 37806 applies, on a of deep inguinal ring or within abdominal cavity,

T8. SUF	RGICAL OPERATION	ONS	5. UROLOGICAL
		TESTIS in inguinal canal close to deep ing on a person under 10 years of age (Anaes.) (
37807	Fee: \$807.45	Benefit: 75% = \$605.60 85% = \$722.75	
	UNDESCENDED (Assist.)	TESTIS, revision orchidopexy for, on a pe	erson 10 years of age or over. (Anaes.)
37809	Fee: \$621.10	Benefit: 75% = \$465.85	
	UNDESCENDED (Assist.)	TESTIS, revision orchidopexy for, on a pe	erson under 10 years of age (Anaes.)
37810	Fee: \$807.45	Benefit: 75% = \$605.60	
		ESTIS, exploration of groin for, not being a 06 and 37809 applies, on a person 10 years of	
37812	Fee: \$573.35	Benefit: 75% = \$430.05	
		ESTIS, exploration of groin for, not being a 07 and 37810 applies, on a person under 10	
37813	Fee: \$745.35	Benefit: 75% = \$559.05	
	HYPOSPADIAS, (Anaes.)	examination under anaesthesia with erection	on test on a person 10 years of age or over.
37815	Fee: \$95.65	Benefit: 75% = \$71.75	
	HYPOSPADIAS, (Anaes.)	examination under anaesthesia with erection	on test, on a person under 10 years of age
37816	Fee: \$124.40	Benefit: 75% = \$93.30	
	HYPOSPADIAS, (Anaes.) (Assist.)	glanuloplasty incorporating meatal advance	ement, on a person 10 years of age or over
37818	Fee: \$506.80	Benefit: 75% = \$380.10 85% = \$430.80	
	HYPOSPADIAS, (Anaes.) (Assist.)	glanuloplasty incorporating meatal advance	ement, on a person under 10 years of age
37819	Fee: \$658.85	Benefit: 75% = \$494.15 85% = \$574.15	
	HYPOSPADIAS,	distal, 1 stage repair, on a person 10 years of	of age or over. (Anaes.) (Assist.)
37821	Fee: \$859.15	Benefit: 75% = \$644.40	
		distal, 1 stage repair, on a person under 10	years of age (Anaes.) (Assist.)
37822	Fee: \$1,116.90	Benefit: 75% = \$837.70	
		proximal, 1 stage repair on a person 10 year	ars of age or over. (Anaes.) (Assist.)
37824	Fee: \$1,194.50	Benefit: 75% = \$895.90	
		proximal, 1 stage repair, on a person under	10 years of age (Anaes.) (Assist.)
37825	Fee: \$1,552.85	Benefit: 75% = \$1164.65	
57025	· ·	staged repair, first stage, on a person 10 year	ars of age or over. (Anaes.) (Assist.)
37827	Fee: \$550.30	Benefit: 75% = \$412.75	
31021	1 cc. \$330.30	DCHCHL. 1370 — \$\phi12.13	

T8. SUF	RGICAL OPERAT	ons	5. UROLOGICAL
	HYPOSPADIAS	, staged repair, first stage, on a person under 10	years of age (Anaes.) (Assist.)
37828	Fee: \$715.35	Benefit: 75% = \$536.55	
	HYPOSPADIAS	, staged repair, second stage, on a person 10 year	rs of age or over. (Anaes.) (Assist.)
37830	Fee: \$713.00	Benefit: 75% = \$534.75 85% = \$628.30	
	HYPOSPADIAS	, staged repair, second stage, on a person under	10 years of age. (Anaes.) (Assist.)
37831	Fee: \$927.00	Benefit: 75% = \$695.25 85% = \$842.30	
	Hypospadias, rep	air of urethral fistula, on a person 10 years of ag	ge or over (Anaes.) (Assist.)
37833	Fee: \$340.30	Benefit: 75% = \$255.25	
	Hypospadias, rep	air of urethral fistula, on a person under 10 year	s of age (Anaes.) (Assist.)
37834	Fee: \$442.35	Benefit: 75% = \$331.80	
		aged repair, first stage (Anaes.) (Assist.)	
37836	Fee: \$716.70	Benefit: 75% = \$537.55	
		aged repair, second stage (Anaes.) (Assist.)	
37839	Fee: \$812.20	Benefit: 75% = \$609.15	
	Exstrophy of blace	dder or epispadias, primary or secondary repair reteric reimplantation (Anaes.) (Assist.)	with or without bladder neck tightening,
37842	Fee: \$1,576.85	Benefit: 75% = \$1182.65	
	Congenital disordendoscopy (Anae	der of sexual differentiation with urogenital sinues.) (Assist.)	s, external genitoplasty, with or without
37845	Fee: \$716.70	Benefit: 75% = \$537.55	
		der of sexual differentiation with urogenital sinu (Anaes.) (Assist.)	s, external genitoplasty with endoscopy
37848	Fee: \$1,290.10	Benefit: 75% = \$967.60	
	Congenital disord (Assist.)	der of sexual differentiation, vaginoplasty for, w	ith or without endoscopy (Anaes.)
37851	Fee: \$955.75	Benefit: 75% = \$716.85	
	Urethral valve, d	estruction of, including cystoscopy and urethrose	copy (Anaes.)
37854	Fee: \$377.90	Benefit: 75% = \$283.45	
T8. SUF	RGICAL OPERAT	ons	6. CARDIO-THORACIC
	Group T8. Surgi	cal Operations	
		Subgroup 6. Cardio-Thora	acic
	Trachea or bronc	hus, dilatation of stricture and endoscopic insert	ion of stent (Anaes.) (Assist.)
New 38426 S	Fee: \$467.50	Benefit: 75% = \$350.65	
		CARDIOLOGY PROCEDUR	ES

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	RIGHT HEART CATHETERISATION, with any one or more of the dye dilution curves, cardiac output measurement by any method, shun (Anaes.)	
38200	Fee: \$459.35 Benefit: 75% = \$344.55 85% = \$390.45	
	LEFT HEART CATHETERISATION by percutaneous arterial punctuleft ventricular puncture with any one or more of the following: fluorocurves, cardiac output measurements by any method, shunt detection	oscopy, oximetry, dye dilution
38203	Fee: \$548.15 Benefit: 75% = \$411.15 85% = \$465.95	
	RIGHT HEART CATHETERISATION WITH LEFT HEART CATH or by any other procedure with any one or more of the following: fluo curves, cardiac output measurements by any method, shunt detection	roscopy, oximetry, dye dilution
38206	Fee: \$662.75 Benefit: 75% = \$497.10 85% = \$578.05	
	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and included 1 or more of syncope, atrioventricular conduction, sinus node function studies, not being a service associated with a service to which item 38	n or simple ventricular tachycardia
38209	(See para TN.8.60 of explanatory notes to this Category) Fee: \$850.95 Benefit: 75% = \$638.25 85% = \$766.25	
	CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more cathet investigation; or complex tachycardia inductions, or multiple catheter antiarrhythmic drug testing with pre and post drug inductions; or cathe complete AV block; or intraoperative mapping; or electrophysiological implantation not being a service associated with a service to which its (Anaes.)	mapping, or acute intravenous eter ablation to intentionally induce al services during defibrillator
38212	(See para TN.8.60 of explanatory notes to this Category) Fee: \$1,415.30 Benefit: 75% = \$1061.50 85% = \$1330.60	
	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up test being a service associated with a service to which item 38209 or 3821	
38213	Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheter into the native coronary arteries, not being a service associated with a 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 a	service to which item 38218,
38215	(See para TN.8.52 of explanatory notes to this Category) Fee: \$366.00 Benefit: 75% = \$274.50 85% = \$311.10	
	SELECTIVE CORONARY ANGIOGRAPHY, placement of catheter with right or left heart catheterisation or both, or aortography, not bein service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38 applies (Anaes.)	ng a service associated with a
38218	(See para TN.8.52 of explanatory notes to this Category) Fee: \$548.85 Benefit: 75% = \$411.65 85% = \$466.55	
38220	SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of material into free coronary graft(s) attached to the aorta (irrespective of a service associated with a service to which item 38215, 38218, 38222, 38237, 38240 or 38246 applies (Anaes.)	of the number of grafts), not being

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	(See para TN.8.52 of explanatory notes to this Category) Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$15	5.55
	Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$15 SELECTIVE CORONARY GRAFT ANGIOGRAPHY, opaque material into direct internal mammary artery gra (irrespective of the number of grafts), not being a service 38218, 38220, 38225, 38228, 38231, 38234, 38237, 382	placement of catheter(s) and injection of ft(s) to one or more coronary arteries e associated with a service to which item 38215,
38222	(See para TN.8.52 of explanatory notes to this Category) Fee: \$366.00 Benefit: 75% = \$274.50 85% = \$31	1.10
	SELECTIVE CORONARY ANGIOGRAPHY, placeme into the native coronary arteries and placement of cathet coronary graft(s) attached to the aorta (irrespective of the associated with a service to which item 38215, 38218, 3 38240 or 38246 applies (Anaes.)	er(s) and injection of opaque material into free e number of grafts), not being a service
38225	(See para TN.8.52 of explanatory notes to this Category) Fee: \$548.95 Benefit: 75% = \$411.75 85% = \$46	6.65
	SELECTIVE CORONARY ANGIOGRAPHY, placeme into the native coronary arteries and placement of cathet internal mammary artery graft(s) to one or more coronar not being a service associated with a service to which ite 38234, 38237, 38240 or 38246 applies (Anaes.)	er(s) and injection of opaque material into direct y arteries (irrespective of the number of grafts),
38228	(See para TN.8.52 of explanatory notes to this Category) Fee: \$732.05 Benefit: 75% = \$549.05 85% = \$64	7.35
	SELECTIVE CORONARY ANGIOGRAPHY, placeme into the native coronary arteries and placement of cathet free coronary graft(s) attached to the aorta (irrespective catheter(s) and injection of opaque material into direct in coronary arteries (irrespective of the number of grafts), which item 38215, 38218, 38220, 38222, 38225, 38228,	er(s) and injection of opaque material into the of the number of grafts), and placement of internal mammary artery graft(s) to one or more not being a service associated with a service to
38231	(See para TN.8.52 of explanatory notes to this Category) Fee: \$914.95 Benefit: 75% = \$686.25 85% = \$83	0.25
	SELECTIVE CORONARY ANGIOGRAPHY, placeme with right or left heart catheterisation or both, or aortogr of opaque material into free coronary graft(s) attached to not being a service associated with a service to which ite 38231, 38237, 38240 or 38246 applies (Anaes.)	aphy and placement of catheter(s) and injection of the aorta (irrespective of the number of grafts),
38234	(See para TN.8.52 of explanatory notes to this Category) Fee: \$731.90 Benefit: 75% = \$548.95 85% = \$64	7.20
	SELECTIVE CORONARY ANGIOGRAPHY, placeme with right or left heart catheterisation or both, or aortogr of opaque material into direct internal mammary artery g (irrespective of the number of grafts), not being a service 38218, 38220, 38222, 38225, 38228, 38231, 38234, 382	aphy and placement of catheter(s) and injection graft(s) to one or more coronary arteries e associated with a service to which item 38215,
38237	(See para TN.8.52 of explanatory notes to this Category) Fee: \$914.90 Benefit: 75% = \$686.20 85% = \$83	0.20
	SELECTIVE CORONARY ANGIOGRAPHY, placeme with right or left heart catheterisation or both, or aortogr	aphy and placement of catheter(s) and injection
38240	of opaque material into free coronary graft(s) attached to	o the aorta (irrespective of the number of grafts)

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	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, 38222, 38237 or 38246 applies (Anaes.)	of grafts), not being a service
	(See para TN.8.52 of explanatory notes to this Category) Fee: \$1,097.85 Benefit: 75% = \$823.40 85% = \$1013.15	
	USE OF A CORONARY PRESSURE WIRE during selective coron fractional flow reserve (FFR) and coronary flow reserve (CFR) in o 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	Fee: \$484.35 Benefit: 75% = \$363.30 85% = \$411.70	
	PLACEMENT OF CATHETER(S) and injection of opaque material graft(s) prior to any coronary interventional procedure, not being a swhich item 38246 applies (Anaes.)	
38243	(See para TN.8.52 of explanatory notes to this Category) Fee: \$457.45 Benefit: 75% = \$343.10 85% = \$388.85	
	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, 38234, 38237, 38238, 382390, 38239, 38239, 38239, 38239, 38239, 38239, 38239, 38239, 3823	yed by placement of catheters prior to d with a service to which item
38246	(See para TN.8.52 of explanatory notes to this Category) Fee: \$914.90 Benefit: 75% = \$686.20 85% = \$830.20	
	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE,	insertion of (Anaes.)
38256	Fee: \$275.60 Benefit: 75% = \$206.70 85% = \$234.30	
	BALLOON VALVULOPLASTY OR ISOLATED ATRIAL SEPT catheterisations before and after balloon dilatation (Anaes.) (Assist.	
38270	Fee: \$940.80 Benefit: 75% = \$705.60 85% = \$856.10	
	ATRIAL SEPTAL DEFECT closure, with septal occluder or other approach (Anaes.) (Assist.)	similar device, by transcatheter
38272	Fee: \$940.80 Benefit: 75% = \$705.60 85% = \$856.10	
	Patent ductus arteriosus, transcatheter closure of, including cardiac associated with the service (Anaes.) (Assist.)	catheterisation and any imaging
38273	Fee: \$940.80 Benefit: 75% = \$705.60	
	Ventricular septal defect, transcatheter closure of, with imaging and (Assist.)	cardiac catheterisation (Anaes.)
38274	Fee: \$940.80 Benefit: 75% = \$705.60	
	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.)	
38275	Fee: \$307.50 Benefit: 75% = \$230.65 85% = \$261.40	
38276	Transcatheter occlusion of left atrial appendage, and cardiac cathete practitioner, for stroke prevention in a patient who has non-valvular contraindication to life-long oral anticoagulation therapy, and is at i	atrial fibrillation and a

T8. SUR	GICAL OPERATIONS 6. CARDIO-THORACI
	demonstrated by:
	(a) a prior stroke (whether of an ischaemic or unknown type), transient ischaemic attack or non-central nervous system systemic embolism; or
	(b) at least 2 of the following risk factors:
	(i) an age of 65 years or more;
	(ii) hypertension;
	(iii) diabetes mellitus;
	(iv) heart failure or left ventricular ejection fraction of 35% or less (or both);
	(v) vascular disease (prior myocardial infarction, peripheral artery disease or aortic plaque)
	(Anaes.) (Assist.)
	(See para TN.8.132 of explanatory notes to this Category) Fee: \$940.80 Benefit: 75% = \$705.60
	IMPLANTABLE ECG LOOP RECORDER, insertion of, for diagnosis of primary disorder in patients with recurrent unexplained syncope where:
	- a diagnosis has not been achieved through all other available cardiac investigations; and
	- a neurogenic cause is not suspected; and
	- it has been determined that the patient does not have structural heart disease associated with a high risk of sudden cardiac death.
	including initial programming and testing, as an admitted patient in an approved hospital (Anaes.)
38285	(See para TN.8.61 of explanatory notes to this Category) Fee: \$198.95 Benefit: 75% = \$149.25 85% = \$169.15
	IMPLANTABLE ECG LOOP RECORDER, removal of, as an admitted patient in an approved hospital (Anaes.)
38286	Fee: \$179.20 Benefit: 75% = \$134.40 85% = \$152.35
	Implantable loop recorder, insertion of, for diagnosis of atrial fibrillation, if:
	(a) the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source; and
	(b) the bases of the diagnosis included the following:
	(i) the medical history of the patient;
	(ii) physical examination;
	(iii) brain and carotid imaging;
38288	(iv) cardiac imaging;

T8. SUR	RGICAL OPERAT	ions	6. CARDIO-THORACIC
	(v) surface ECG	testing including 24-hour Holter monitoring; and	
	(c) atrial fibrillati	ion is suspected; and	
	(d) the patient:		
	(i) does not have	a permanent indication for oral anticoagulants; or	•
	(ii) does not have	e a permanent oral anticoagulants contraindication	;
	including initial	programming and testing	
		grogiuming and testing	
	(Anaes.)	7	
	Fee: \$198.95	Benefit: 75% = \$149.25 85% = \$169.15	
		CATHETER BASED ARRHYTHMIA A	BLATION
	ABLATION OF chamber (Anaes.	ARRHYTHMIA CIRCUIT OR FOCUS or isolati (Assist.)	ion procedure involving 1 atrial
38287	Fee: \$2,164.05	Benefit: 75% = \$1623.05 85% = \$2079.35	
		ARRHYTHMIA CIRCUITS OR FOCI, or isolaticluding curative procedures for atrial fibrillation (A	
38290	Fee: \$2,755.40	Benefit: 75% = \$2066.55	
		R ARRHYTHMIA with mapping and ablation, incical studies performed on the same day (Anaes.) (Anaes.)	
38293	Fee: \$2,957.65	Benefit: 75% = \$2218.25 85% = \$2872.95	
		ENDOVASCULAR INTERVENTIONAL PF	ROCEDURES
		AL BALLOON ANGIOPLASTY of 1 coronary aring associated radiological services or preparation	
38300	Fee: \$531.45	Benefit: 75% = \$398.60 85% = \$451.75	
		AL BALLOON ANGIOPLASTY of more than 1 oxcluding associated radiological services or prepa	
38303	Fee: \$681.40	Benefit: 75% = \$511.05 85% = \$596.70	
	of coronary arter	ertion of stent or stents into one occlusional site, is y, percutaneous or by open exposure, excluding as aration and after-care (Anaes.) (Assist.)	•
38306	(See para TN.8.62 Fee: \$786.15	of explanatory notes to this Category) Benefit: 75% = \$589.65 85% = \$701.45	
		US TRANSLUMINAL ROTATIONAL ATHERE an angioplasty with no stent insertion, where:	ECTOMY of 1 coronary artery,
38309	- no lesion of th	ne coronary artery has been stented; and	

PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,253.85 Benefit: 75% = \$940.40 85% = \$1169.15 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95	T8. SUR	GICAL OPERATIONS	6. CARDIO-THORACIC
excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$913.10 Benefit: 75% = \$684.85 85% = \$828.40 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty with insertion of 1 or more stents, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,167.70 Benefit: 75% = \$875.80 85% = \$1083.00 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,253.85 Benefit: 75% = \$940.40 85% = \$1169.15 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries has been stented; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, remov		- each lesion of the coronary artery is complex and heavily calcified; and	
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including balloon angioplasty with insertion of 1 or more stents, where: - no lesion of the coronary artery has been stented; and - each lesion of the coronary artery is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,167.70			
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Fee: \$1,167.70 Benefit: 75% = \$875.80 85% = \$1083.00		excluding associated radiological services or preparation, and excluding after	ercare (Anaes.) (Assist.)
artery, including balloon angioplasty with no stent insertion, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,253.85 Benefit: 75% = \$940.40 85% = \$1169.15 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95	38312		
- each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,253.85			Y of more than 1 coronary
- balloon angioplasty with or without stenting is not suitable; excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,253.85 Benefit: 75% = \$940.40 85% = \$1169.15 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		- no lesion of the coronary arteries has been stented; and	
excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,253.85 Benefit: 75% = \$940.40 85% = \$1169.15 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		- each lesion of the coronary arteries is complex and heavily calcified; and	d
(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,253.85 Benefit: 75% = \$940.40 85% = \$1169.15 PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		- balloon angioplasty with or without stenting is not suitable;	
PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		excluding associated radiological services or preparation, and excluding after	ercare (Anaes.) (Assist.)
artery, including balloon angioplasty, with insertion of 1 or more stents, where: - no lesion of the coronary arteries has been stented; and - each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95	38315		
- each lesion of the coronary arteries is complex and heavily calcified; and - balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95			
- balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		- no lesion of the coronary arteries has been stented; and	
excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) (See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		- each lesion of the coronary arteries is complex and heavily calcified; and	d
(See para TN.8.41 of explanatory notes to this Category) Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		- balloon angioplasty with or without stenting is not suitable,	
38318 Fee: \$1,635.95 Benefit: 75% = \$1227.00 85% = \$1551.25 MISCELLANEOUS CARDIAC PROCEDURES SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		excluding associated radiological services or preparation, and excluding after	ercare (Anaes.) (Assist.)
SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95	38318		
replacement of, including cardiac electrophysiological services where used for pacemaker implantation (Anaes.) (See para TN.8.60 of explanatory notes to this Category) Fee: \$658.60 Benefit: 75% = \$493.95		MISCELLANEOUS CARDIAC PROCEDURES	S
38350 Fee: \$658.60 Benefit: 75% = \$493.95		replacement of, including cardiac electrophysiological services where used	
DEDMANENT CADDIAC DACEMAKED insertion removed or replacement of not for condice	38350		
30333 LEKWANENT CARDIAC FACEWARER, HISERUOH, TEHIOVAL OF TEPIACEHIER OF, HOLTOT CARDIAC	38353	PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement	ent of, not for cardiac

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	resynchronisation therapy, including cardiac electrophysiological services whimplantation (Anaes.)	nere used for pacemaker
	(See para TN.8.60 of explanatory notes to this Category) Fee: \$263.45 Benefit: 75% = \$197.60	
	DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, inser replacement of, including cardiac electrophysiological services where used for (Anaes.)	
38356	(See para TN.8.60 of explanatory notes to this Category) Fee: \$863.50 Benefit: 75% = \$647.65	
	Extraction of chronically implanted transvenous pacing or defibrillator lead of method where the leads have been in situ for greater than six months and requestylets, snares and/or extraction sheaths in a facility where cardiac surgery is with item 61109 or 60509 (Anaes.) (Assist.)	aire removal with locking
38358	(See para TN.8.64 of explanatory notes to this Category) Fee: \$2,957.65 Benefit: 75% = \$2218.25	
	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.)	
38359	Fee: \$137.75 Benefit: 75% = \$103.35 85% = \$117.10	
	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.)	
38362	Fee: \$396.95 Benefit: 75% = \$297.75 85% = \$337.45	
	Permanent cardiac synchronisation device (including a cardiac synchronisation defibrillation), insertion, removal or replacement of, for a patient who:	on device that is capable of
	(a) has:	
	(i) moderate to severe chronic heart failure (New York Heart Association despite optimised medical therapy; and	on (NYHA) class III or IV)
	(ii) sinus rhythm; and	
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and	
	(iv) a QRS duration greater than or equal to 120 ms; or	
	(b) satisfied the requirements mentioned in paragraph (a) immediately before resynchronisation therapy device and transvenous left ventricle electrode	
38365	(See para TN.8.63 of explanatory notes to this Category) Fee: \$263.45 Benefit: 75% = \$197.60	
	Permanent transvenous left ventricular electrode, insertion, removal or replace coronary sinus, for the purpose of cardiac resynchronisation therapy, including and any associated venogram of left ventricular veins, other than a service assumble them 35200 or 38200 applies, for a patient who:	g right heart catheterisation
	(a) has:	
38368	(i) moderate to severe chronic heart failure (New York Heart Association despite optimised medical therapy; and	on (NYHA) class III or IV)

T8. SURGICAL OPERATIONS 6. CARDIO-THORACIC (ii) sinus rhythm; and a left ventricular ejection fraction of less than or equal to 35%; and a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and sinus rhythm; and (ii) a left ventricular ejection fraction of less than or equal to 35%; and (iii) 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: \$1.262.85 **Benefit:** 75% = \$947.15 Permanent cardiac synchronisation device capable of defibrillation, insertion, removal or replacement of, for a patient who: (a) has: moderate to severe chronic heart failure (New York Heart Association ((NYHA) class III or IV) despite optimised medical therapy; and sinus rhythm; and (ii) a left ventricular ejection fraction of less than or equal to 35%; and (iii) a QRS duration greater than or equal to 120 ms; or (b) has: (i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and sinus rhythm; and a left ventricular ejection fraction of less than or equal to 35%; and a QRS duration greater than or equal to 150 ms (Anaes.) (See para TN.8.65 of explanatory notes to this Category) 38371 **Fee:** \$296.85 **Benefit:** 75% = \$222.65 AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrodes for, primary prevention of sudden cardiac death in: 38384 - patients with a left ventricular ejection fraction of less than or equal to 30% at least one month after

T8. SUR	GICAL OPERAT	FIONS	6. CARDIO-THOR	ACIC
	a myocardial	infarct when the patient has r	received optimised medical therapy; or	
	and a left vent		ated with mild to moderate symptoms (NYHA II and II s than or equal to 35% when the patient has received	II)
	Not being a servi	vice associated with a service	e to which item 38213 applies (Anaes.) (Assist.)	
	Fee: \$1,085.55	Benefit: 75% = \$814.20	85% = \$1000.85	
	AUTOMATIC Dof sudden cardiac		ATOR, insertion or replacement of for, primary preven	ition
			raction of less than or equal to 30% at least one month a received optimised medical therapy; or	after
	and a left vent		ated with mild to moderate symptoms (NYHA II and II s than or equal to 35% when the patient has received	II)
	_	vice associated with a service chronisation therapy (Anaes.)	e to which item 38213 applies, not for defibrillators cap.) (Assist.)	pable
38387	Fee: \$296.85	Benefit: 75% = \$222.65	85% = \$252.35	
	defibrillation elec	ectrodes for - not for patients	n of patches for, or insertion of transvenous endocardia s with heart failure or as primary prevention for tachyca with a service to which item 38213 applies (Anaes.)	
38390	Fee: \$1,085.55	Benefit: 75% = \$814.20	85% = \$1000.85	
	heart failure or as		ATOR, insertion or replacement of for - not for patients chycardia arrhythmias. Not being a service associated v.) (Assist.)	
38393	Fee: \$296.85	Benefit: 75% = \$222.65	85% = \$252.35	
		THO	ORACIC SURGERY	
	EMPYEMA, rad	dical operation for, involving	g resection of rib (Anaes.) (Assist.)	
38415	Fee: \$411.85	Benefit: 75% = \$308.90	85% = \$350.10	
	Endoscopic ultra	asound guided fine needle asr	spiration biopsy or biopsies (endoscopy with ultrasound	I
	imaging) to obtain		rom either or both of the following:	

T8. SUR	GICAL OPERATIO	NS	6. CARDIO-THORACIC
	(b) locoregional no	des to stage non-small cell lung carcinoma;	
	other than a service 38417 or 55054, ap	e associated with a service to which an item in Subgrouplies (Anaes.)	oup 1 of this Group, or item
	(See para TN.8.21 of Fee: \$580.90	explanatory notes to this Category) Benefit: 75% = \$435.70 85% = \$496.20	
		asound guided biopsy or biopsies (bronchoscopy with fluoroscopic imaging) to obtain one or more specime	Ç Ç.
	(a) transbronchial b	piopsy or biopsies of peripheral lung lesions; or	
	(b) fine needle aspi	rations of one or more mediastinal masses; or	
	(c) fine needle aspir	rations of locoregional nodes to stage non-small cell	lung carcinoma;
		associated with a service to which an item in Subgroup I3 of Group I3, applies (Anaes	
New 38417 S	(See para TN.8.21 of Fee: \$580.90	explanatory notes to this Category) Benefit: 75% = \$435.70 85% = \$496.20	
	THORACOTOMY	, exploratory, with or without biopsy (Anaes.) (Assis	st.)
38418	Fee: \$988.35	Benefit: 75% = \$741.30	
	Bronchoscopy, as a	un independent procedure (Anaes.)	
New 38419 S	Fee: \$183.60	Benefit: 75% = \$137.70 85% = \$156.10	
	Bronchoscopy with (Anaes.)	one or more endobronchial biopsies or other diagno	stic or therapeutic procedures
New 38420 S	Fee: \$242.40	Benefit: 75% = \$181.80 85% = \$206.05	
	THORACOTOMY	, with pulmonary decortication (Anaes.) (Assist.)	
38421	Fee: \$1,579.85	Benefit: 75% = \$1184.90	
	Bronchus, removal	of foreign body in (Anaes.) (Assist.)	
New 38422 S	Fee: \$379.25	Benefit: 75% = \$284.45	
		scopy with one or more transbronchial lung biopsies, wage, with or without the use of interventional imagi	
New 38423 S	Fee: \$264.95	Benefit: 75% = \$198.75 85% = \$225.25	
	THORACOTOMY (Anaes.) (Assist.)	, with pleurectomy or pleurodesis, OR ENUCLEAT	ION OF HYDATID cysts
38424	Fee: \$988.35	Benefit: 75% = \$741.30	
		esection of endobronchial tumours for relief of obstructures (Anaes.) (Assist.)	action including any associated
New 38425 S	Fee: \$623.15	Benefit: 75% = \$467.40	
JUT2J B		TY (complete) - 3 or more ribs (Anaes.) (Assist.)	
28/127		_	
38427	Fee: \$1,220.40	Benefit: 75% = \$915.30	

T8. SURGICAL OPERATIONS 6. CARDIO-T		ONS 6. CARDIO-THORACIC
	THORACOPLAS	TY (in stages) each stage (Anaes.) (Assist.)
38430	Fee: \$628.95	Benefit: 75% = \$471.75
		PY, with or without division of pleural adhesions, including insertion of intercostal cessary, with or without biopsy (Anaes.)
38436	Fee: \$257.55	Benefit: 75% = \$193.20
		DMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a tem 38418 applies (Anaes.) (Assist.)
38438	Fee: \$1,579.85	Benefit: 75% = \$1184.90
	LUNG, wedge res	section of (Anaes.) (Assist.)
38440	Fee: \$1,183.05	Benefit: 75% = \$887.30
		ECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, ormal mediastinal node dissection (Anaes.) (Assist.)
38441	Fee: \$1,871.90	Benefit: 75% = \$1403.95
	THORACOTOM	Y or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.)
38446	Fee: \$1,220.40	Benefit: 75% = \$915.30
	PERICARDIECT (Anaes.) (Assist.)	OMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass
38447	Fee: \$1,579.85	Benefit: 75% = \$1184.90
	MEDIASTINUM	, cervical exploration of, with or without biopsy (Anaes.) (Assist.)
38448	Fee: \$374.40	Benefit: 75% = \$280.80
	PERICARDIECT (Anaes.) (Assist.)	OMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass
38449	Fee: \$2,210.15	Benefit: 75% = \$1657.65
	PERICARDIUM,	transthoracic open surgical drainage of (Anaes.) (Assist.)
38450	Fee: \$883.40	Benefit: 75% = \$662.55
	PERICARDIUM,	subxiphoid open surgical drainage of (Anaes.) (Assist.)
38452	Fee: \$591.65	Benefit: 75% = \$443.75
	TRACHEAL exc	sion and repair without cardiopulmonary bypass (Anaes.) (Assist.)
38453	Fee: \$1,774.70	Benefit: 75% = \$1331.05
	TRACHEAL EX	CISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.)
38455	Fee: \$2,400.40	Benefit: 75% = \$1800.30
	INTRATHORAC	IC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or on more than 1 of those organs, not being a service to which another item in this Group
	applies (Times.)	

T8. SUF	RGICAL OPERATI	ONS	6. CARDIO-THORACIC
	PECTUS EXCAV	ATUM or PECTUS CARINATO	JM, repair or radical correction of (Anaes.) (Assist.)
38457	Fee: \$1,474.95	Benefit: 75% = \$1106.25	
	PECTUS EXCAV	ATUM, repair of, with implanta	tion of subcutaneous prosthesis (Anaes.) (Assist.)
38458	Fee: \$786.15	Benefit: 75% = \$589.65	
	STERNAL WIRE	OR WIRES, removal of (Anaes.)
38460	Fee: \$284.00	Benefit: 75% = \$213.00	
	STERNOTOMY	WOUND, debridement of, not in	volving reopening of the mediastinum (Anaes.)
38462	Fee: \$336.60	Benefit: 75% = \$252.45	
		WOUND, debridement of, involving the not involving reopening of the	ring curettage of infected bone with or without e mediastinum (Anaes.)
38464	Fee: \$365.90	Benefit: 75% = \$274.45	
	STERNUM, reop without rewiring		ction involving reopening of the mediastinum, with or
38466	Fee: \$987.95	Benefit: 75% = \$741.00	
		MEDIASTINUM, reoperation form (Anaes.) (Assist.)	or infection of, involving muscle advancement flaps
38468	Fee: \$1,522.25	Benefit: 75% = \$1141.70	
	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.)		or infection of, involving muscle advancement flaps
38469	Fee: \$1,774.70	Benefit: 75% = \$1331.05	
		CARDIAC SURG	ERY PROCEDURES
	PERMANENT M (Assist.)	YOCARDIAL ELECTRODE, in	sertion of, by thoracotomy or sternotomy (Anaes.)
38470	(See para TN.8.67 o Fee: \$988.35	of explanatory notes to this Category) Benefit: 75% = \$741.30	
	PERMANENT P.	ACEMAKER ELECTRODE, inse	ertion by open surgical approach (Anaes.) (Assist.)
38473	(See para TN.8.67 o Fee: \$591.65	of explanatory notes to this Category) Benefit: 75% = \$443.75	
			PROCEDURES
		OPLASTY without insertion of r or 38481 applies (Anaes.) (Assis	ing, not being a service associated with a service to it.)
38475	(See para TN.8.67 o Fee: \$857.75	of explanatory notes to this Category) Benefit: 75% = \$643.35	
	VALVE ANNUL (Anaes.) (Assist.)	OPLASTY with insertion of ring	not being a service to which item 38478 applies
38477	(See para TN.8.67 o Fee: \$2,065.95	of explanatory notes to this Category) Benefit: 75% = \$1549.50	
38478	VALVE ANNUL	OPLASTY with insertion of ring	performed in conjunction with item 38480 or 38481

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIC
	(Anaes.) (Assist.)
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,000.75 Benefit: 75% = \$750.60
	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.)
38480	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,065.95 Benefit: 75% = \$1549.50
	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.)
38481	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,351.90 Benefit: 75% = \$1763.95
	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies (Anaes.) (Assist.)
38483	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,774.70 Benefit: 75% = \$1331.05
	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.)
38485	(See para TN.8.67 of explanatory notes to this Category) Fee: \$842.60 Benefit: 75% = \$631.95
	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.)
38487	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,774.70 Benefit: 75% = \$1331.05
	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.)
38488	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,969.25 Benefit: 75% = \$1476.95
	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.)
38489	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,342.00 Benefit: 75% = \$1756.50
	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.)
38490	(See para TN.8.67 of explanatory notes to this Category) Fee: \$571.85 Benefit: 75% = \$428.90
	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.)
38493	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,018.75 Benefit: 75% = \$1514.10
	TAVI, for the treatment of symptomatic severe aortic stenosis, performed via transfemoral delivery, unless transfemoral delivery is contraindicated or not feasible, in a TAVI Hospital on a TAVI Patient by a TAVI Practitioner – includes all intraoperative diagnostic imaging that the TAVI Practitioner performs upon the TAVI Patient.
38495	(Not payable more than once per patient in a five year period.) (Anaes.) (Assist.)

T8. SUI	RGICAL OPERATIONS 6. CARDIO-THORACI
	(See para AN.33.1, TN.8.135 of explanatory notes to this Category) Fee: \$1,476.95 Benefit: 75% = \$1107.75 85% = \$1392.25
	SURGERY FOR ISCHAEMIC HEART DISEASE
	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.)
38496	(See para TN.8.67 of explanatory notes to this Category) Fee: \$643.45 Benefit: 75% = \$482.60
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service associated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply (Anaes.) (Assist.)
38497	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,111.55 Benefit: 75% = \$1583.70
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503, 38504 or 38600 apply (Anaes.) (Assist.)
38498	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,111.55 Benefit: 75% = \$1583.70
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply (Anaes.) (Assist.)
38500	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,268.75 Benefit: 75% = \$1701.60
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associate with a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply (Anaes.) (Assist.)
38501	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,268.75 Benefit: 75% = \$1701.60
	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38500, 38501 or 38504 apply (Anaes.) (Assist.)
38503	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,463.30 Benefit: 75% = \$1847.50
	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associate with a service to which items 38497, 38498, 38500, 38501, 38503 or 38600 apply (Anaes.) (Assist.)
38504	(See para TN.8.68, TN.8.67 of explanatory notes to this Category) Fee: \$2,463.30 Benefit: 75% = \$1847.50
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts,

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORACIC
	each vessel (Anaes.) (Assist.)
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$285.95 Benefit: 75% = \$214.50
	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.)
38506	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,677.05 Benefit: 75% = \$1257.80
	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.)
38507	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,968.85 Benefit: 75% = \$1476.65
	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.)
38508	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,463.30 Benefit: 75% = \$1847.50
	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.)
38509	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,463.30 Benefit: 75% = \$1847.50
	ARRHYTHMIA SURGERY
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.)
38512	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,164.05 Benefit: 75% = \$1623.05
	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.)
38515	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,755.40 Benefit: 75% = \$2066.55
	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.)
38518	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,957.65 Benefit: 75% = \$2218.25
	PROCEDURES ON THORACIC AORTA
	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.)
38550	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,213.20 Benefit: 75% = \$1659.90
	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.)
38553	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,804.70 Benefit: 75% = \$2103.55
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,201.70 Benefit: 75% = \$2401.30	
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement or repair or coronary artery implantation (Anaes.) (Assist.)	lacement of, not involving valve
38559	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,610.05 Benefit: 75% = \$1957.55	
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement or repair, without implantation of coronary arteries (Anaes.)	
38562	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,201.70 Benefit: 75% = \$2401.30	
	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement or repair, and implantation of coronary arteries (Anaes.) (As	
38565	(See para TN.8.67 of explanatory notes to this Category) Fee: \$3,591.00 Benefit: 75% = \$2693.25	
	DESCENDING THORACIC AORTA, repair or replacement of, without bypass, by open exposure, percutaneous or endovascular means (Anaes.)	
38568	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,921.15 Benefit: 75% = \$1440.90	
	DESCENDING THORACIC AORTA, repair or replacement of, using sl (Anaes.) (Assist.)	nunt or cardiopulmonary bypass
38571	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,115.85 Benefit: 75% = \$1586.90	
	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTI procedures on the thoracic aorta (Anaes.) (Assist.)	ION, in conjunction with
38572	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,049.15 Benefit: 75% = \$1536.90	
	CANNULATION FOR, and supervision and monitoring of, the administ perfusion during deep hypothermic arrest (Assist.)	ration of retrograde cerebral
38577	(See para TN.8.67 of explanatory notes to this Category) Fee: \$571.85 Benefit: 75% = \$428.90	
	TECHNIQUES FOR PRESERVATION OF ARREST	ED HEART
	CANNULATION of the coronary sinus for, and supervision of, the retro crystalloid for cardioplegia, including pressure monitoring (Assist.)	grade administration of blood or
38588	(See para TN.8.67 of explanatory notes to this Category) Fee: \$429.05 Benefit: 75% = \$321.80	
	CIRCULATORY SUPPORT PROCEDURE	ES
	CENTRAL CANNULATION for cardiopulmonary bypass excluding pobeing a service associated with a service to which another item in this Su (Assist.)	
38600	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,579.85 Benefit: 75% = \$1184.90	
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding	g post-operative management

T8. SUR	RGICAL OPERATIONS 6. CARDIO-THORACI
	(Anaes.) (Assist.)
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$988.35 Benefit: 75% = \$741.30
	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.)
38609	(See para TN.8.67 of explanatory notes to this Category) Fee: \$494.10 Benefit: 75% = \$370.60
	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.)
38612	(See para TN.8.67 of explanatory notes to this Category) Fee: \$553.90 Benefit: 75% = \$415.45 85% = \$470.85
	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.)
38613	(See para TN.8.67 of explanatory notes to this Category) Fee: \$695.10 Benefit: 75% = \$521.35
	Insertion of a left or right ventricular assist device, for use as:
	(a) a bridge to cardiac transplantation in patients with refractory heart failure who are:
	(i) currently on a heart transplant waiting list, or
	(ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular
	assist device; or
	(b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or
	(c) cardio-respiratory support for acute cardiac failure which is likely to recover with short term support of less than 6
	weeks;
	not being a service associated with the use of a ventricular assist device as destination therapy in the management of patients with heart failure who are not expected to be suitable candidates for cardiac transplantation (Anaes.) (Assist.)
38615	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,579.85 Benefit: 75% = \$1184.90
	Insertion of a left and right ventricular assist device, for use as:
	(a) a bridge to cardiac transplantation in patients with refractory heart failure who are:
	(i) currently on a heart transplant waiting list, or
	(ii) expected to be suitable candidates for cardiac transplantation following a period of support on the ventricular
	assist device; or
38618	(b) acute post cardiotomy support for failure to wean from cardiopulmonary transplantation; or

T8. SUF	RGICAL OPERATIONS	6. CARDIO-THORACIC
	(c) cardio-respiratory support for acute cardiac failure which is likely to reco- support of less than 6	ver with short term
	weeks;	
	not being a service associated with the use of a ventricular assist device as dest management of patients with heart failure who are not expected to be suitable of transplantation (Anaes.) (Assist.)	
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,969.25 Benefit: 75% = \$1476.95	
	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an inde (Anaes.) (Assist.)	pendent procedure
38621	(See para TN.8.67 of explanatory notes to this Category) Fee: \$786.15 Benefit: 75% = \$589.65	
	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an inc (Anaes.) (Assist.)	lependent procedure
38624	(See para TN.8.67 of explanatory notes to this Category) Fee: \$883.40 Benefit: 75% = \$662.55	
	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VEN' DEVICE CANNULAE, adjustment and re-positioning of, by open operation, it these devices (Anaes.) (Assist.)	
38627	(See para TN.8.67 of explanatory notes to this Category) Fee: \$690.50 Benefit: 75% = \$517.90	
	RE-OPERATION	
	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, d oversewing of (Anaes.) (Assist.)	isconnection and
38637	(See para TN.8.67 of explanatory notes to this Category) Fee: \$571.85 Benefit: 75% = \$428.90	
	RE-OPERATION via median sternotomy, for any procedure, including any div where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (As	
38640	(See para TN.8.69, TN.8.67 of explanatory notes to this Category) Fee: \$988.35 Benefit: 75% = \$741.30	
	MISCELLANEOUS CARDIOTHORACIC SURGICAL PROCE	DURES
	THORACOTOMY OR STERNOTOMY involving division of adhesions wher the adhesions exceeds 45 minutes (Anaes.) (Assist.)	e the time taken to divide
38643	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,100.75 Benefit: 75% = \$825.60	
	THORACOTOMY OR STERNOTOMY involving division of extensive adhes to divide the adhesions exceeds 2 hours (Anaes.) (Assist.)	ions where the time taken
38647	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,201.20 Benefit: 75% = \$1650.90	
	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopath	ny (Anaes.) (Assist.)
38650	(See para TN.8.67 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAC
	Fee: \$1,969.25 Benefit: 75% = \$1476.95
	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.)
38653	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,969.25 Benefit: 75% = \$1476.95
	Permanent left ventricular electrode, insertion, removal or replacement of via open thoracotomy, for the purpose of cardiac resynchronisation therapy, for a patient who:
	(a) has:
	(i) moderate to severe chronic heart failure (New York Heart Association (NYHA) class III or IV despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 120 ms; or
	(b) has:
	(i) mild chronic heart failure (New York Heart Association (NYHA) class II) despite optimised medical therapy; and
	(ii) sinus rhythm; and
	(iii) a left ventricular ejection fraction of less than or equal to 35%; and
	(iv) a QRS duration greater than or equal to 150 ms; or
	(c) satisfied the requirements mentioned in paragraph (a) or (b) immediately before the insertion of a cardiac resynchronisation therapy device and transvenous left ventricle electrode
	(Anaes.) (Assist.)
38654	(See para TN.8.63, TN.8.67 of explanatory notes to this Category) Fee: \$1,262.85 Benefit: 75% = \$947.15
	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.)
38656	(See para TN.8.67 of explanatory notes to this Category) Fee: \$988.35 Benefit: 75% = \$741.30
	CARDIAC TUMOURS
	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without pat or conduit reconstruction (Anaes.) (Assist.)
38670	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,968.85 Benefit: 75% = \$1476.65
	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.)
38673	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,216.00 Benefit: 75% = \$1662.00
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.)

T8. SUF	RGICAL OPERATIONS 6. CARDIO-THORAC
	(Assist.)
	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,073.15 Benefit: 75% = \$1554.90
	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repai or reconstruction (Anaes.) (Assist.)
38680	Fee: \$2,459.05 Benefit: 75% = \$1844.30 85% = \$2374.35
	CONGENITAL CARDIAC SURGERY
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38700	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,100.75 Benefit: 75% = \$825.60
	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38703	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,984.20 Benefit: 75% = \$1488.15
	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38706	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,879.30 Benefit: 75% = \$1409.50
	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38709	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,201.20 Benefit: 75% = \$1650.90
	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.)
38712	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,643.20 Benefit: 75% = \$1982.40
	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, f congenital heart disease (Anaes.) (Assist.)
38715	(See para TN.8.67 of explanatory notes to this Category) Fee: \$1,759.60 Benefit: 75% = \$1319.70
	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.)
38718	(See para TN.8.67 of explanatory notes to this Category) Fee: \$2,201.20 Benefit: 75% = \$1650.90
	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) Fee: \$1,542.55 Benefit: 75% = \$1156.95
	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)

T8. SUF	RGICAL OPERATION	ONS	6. CARDIO-THORACIC	
	Fee: \$2,201.20	Benefit: 75% = \$1650.90		
	service to which i		epair of, without cardiopulmonary bypass, not being a 19, 38712, 38715, 38718, 38721 or 38724 applies, for	
38727	(See para TN.8.67 o Fee: \$1,542.55	of explanatory notes to this Categor Benefit: 75% = \$1156.95	y)	
	service to which i		epair of, with cardiopulmonary bypass, not being a 19, 38712, 38715, 38718, 38721 or 38724 applies, for	
38730	Fee: \$2,201.20	Benefit: 75% = \$1650.90		
		MONARY or CAVO-PULMO nital heart disease (Anaes.) (Ass	NARY SHUNT, creation of, without cardiopulmonary sist.)	
38733	(See para TN.8.67 o Fee: \$1,542.55	of explanatory notes to this Categor Benefit: 75% = \$1156.95	y)	
		MONARY or CAVO-PULMO nital heart disease (Anaes.) (Ass	NARY SHUNT, creation of, with cardiopulmonary sist.)	
38736	(See para TN.8.67 o Fee: \$2,201.20	of explanatory notes to this Categor Benefit: 75% = \$1650.90	y)	
	ATRIAL SEPTEO (Anaes.) (Assist.)		pulmonary bypass, for congenital heart disease	
38739	(See para TN.8.67 o Fee: \$1,984.20	of explanatory notes to this Categor Benefit: 75% = \$1488.15	y)	
	ATRIAL SEPTA disease (Anaes.) (• •	posure direct suture or patch, for congenital heart	
38742	(See para TN.8.67 o Fee: \$1,984.20	of explanatory notes to this Categor Benefit: 75% = \$1488.15	y)	
	INTRA-ATRIAL	BAFFLE, insertion of, for cong	genital heart disease (Anaes.) (Assist.)	
38745		of explanatory notes to this Categor Benefit: 75% = \$1650.90	y)	
	VENTRICULAR	SEPTECTOMY, for congenita	l heart disease (Anaes.) (Assist.)	
38748	(See para TN.8.67 o Fee: \$2,201.20	of explanatory notes to this Categor Benefit: 75% = \$1650.90	y)	
	Ventricular septal	defect, closure by direct suture	or patch (Anaes.) (Assist.)	
38751	(See para TN.8.67 o Fee: \$2,201.20	of explanatory notes to this Categor Benefit: 75% = \$1650.90	y)	
	INTRAVENTRIC (Assist.)	CULAR BAFFLE OR CONDU	T, insertion of, for congenital heart disease (Anaes.)	
38754	(See para TN.8.67 o Fee: \$2,755.40	of explanatory notes to this Categor Benefit: 75% = \$2066.55	y)	
	EXTRACARDIA	C CONDUIT, insertion of, for	congenital heart disease (Anaes.) (Assist.)	
38757	(See para TN.8.67	of explanatory notes to this Categor	y)	

T8. SUR	JRGICAL OPERATIONS		6. CARDIO-THORACIO	
	Fee: \$2,201.20	Benefit: 75% = \$1650.90		
	EXTRACARDIA	C CONDUIT, replacement of, for cor	ngenital heart disease (Anaes.) (Assist.)	
38760	(See para TN.8.67 Fee: \$2,201.20	of explanatory notes to this Category) Benefit: 75% = \$1650.90		
	VENTRICULAR disease (Anaes.)		ar obstruction, right or left, for congenital heart	
38763	(See para TN.8.67 Fee: \$2,201.20	of explanatory notes to this Category) Benefit: 75% = \$1650.90		
	VENTRICULAR	AUGMENTATION, right or left, for	congenital heart disease (Anaes.) (Assist.)	
38766	(See para TN.8.67 Fee: \$2,201.20	of explanatory notes to this Category) Benefit: 75% = \$1650.90		
		MISCELLANEOUS PROCED	URES ON THE CHEST	
		VITY, aspiration of, for diagnostic pur tem 38803 applies	poses, not being a service associated with a	
38800	Fee: \$39.70	Benefit: 75% = \$29.80 85% = \$33	75	
	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample			
38803	Fee: \$79.30	Benefit: 75% = \$59.50 85% = \$67	45	
	INTERCOSTAL	DRAIN, insertion of, not involving re	section of rib (excluding aftercare) (Anaes.)	
38806	Fee: \$137.75	Benefit: 75% = \$103.35 85% = \$1	17.10	
	INTERCOSTAL aftercare) (Anaes	-	s and not involving resection of rib (excluding	
38809	Fee: \$169.70	Benefit: 75% = \$127.30 85% = \$1	44.25	
	PERCUTANEOU	JS NEEDLE BIOPSY of lung (Anaes.)	
38812	Fee: \$215.70	Benefit: 75% = \$161.80 85% = \$1	83.35	
T8. SUR	GICAL OPERATI	ONS	7. NEUROSURGICAL	
	Group T8. Surgi	cal Operations		
	Subgroup 7. Neurosurgical			
	GENERAL			
	LUMBAR PUNCTURE (Anaes.)			
39000	Fee: \$77.65	Benefit: 75% = \$58.25 85% = \$66	05	
	Procedure to obtain access to intracranial space (including subdural space, ventricle or b percutaneously or by burr-hole (Anaes.)		ng subdural space, ventricle or basal cistern),	
39007	Fee: \$164.40	Benefit: 75% = \$123.30 85% = \$1	39.75	
39013			th 1 or more of contrast media, local anaesthetic to-transverse joints or 1 or more primary	

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGICAL	
	posterior rami of spinal nerves (Anaes.)	
	(See para TN.8.4 of explanatory notes to this Category) Fee: \$112.55 Benefit: 75% = \$84.45 85% = \$95.70	
	Intracranial parenchymal pressure monitoring device, insertion of—including burr hole (excluding after care) (Anaes.)	
39015	(See para TN.8.4, TN.8.166 of explanatory notes to this Category) Fee: \$387.75 Benefit: 75% = \$290.85	
	Cerebrospinal reservoir, ventricular reservoir or external ventricular drain, insertion of, with or without stereotaxy (Anaes.) (Assist.)	
39018	Fee: \$852.50 Benefit: 75% = \$639.40	
	PAIN RELIEF	
	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.)	
39100	(See para TN.8.4 of explanatory notes to this Category) Fee: \$245.00 Benefit: 75% = \$183.75 85% = \$208.25	
	Trigeminal gangliotomy by radiofrequency, balloon or glycerol, including stereotaxy (Anaes.) (Assist.)	
39109	Fee: \$1,461.90 Benefit: 75% = \$1096.45 85% = \$1377.20	
	Cranial nerve, neurectomy or intracranial decompression of, using microsurgical techniques, including stereotaxy and cranioplasty (Anaes.) (Assist.)	
39113	Fee: \$2,452.40 Benefit: 75% = \$1839.30	
	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.)	
39115	(See para TN.8.4 of explanatory notes to this Category) Fee: \$77.65 Benefit: 75% = \$58.25 85% = \$66.05	
	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.)	
39118	(See para TN.8.4 of explanatory notes to this Category) Fee: \$307.15 Benefit: 75% = \$230.40 85% = \$261.10	
	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.)	
39121	(See para TN.8.4 of explanatory notes to this Category) Fee: \$651.50 Benefit: 75% = \$488.65 85% = \$566.80	
	CORDOTOMY OR MYELOTOMY, partial or total laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.)	
39124	Fee: \$1,667.30 Benefit: 75% = \$1250.50	
	Intrathecal or epidural SPINAL CATHETER insertion or replacement of, and connection to a subcutaneous implanted infusion pump, for the management of chronic intractable pain (Anaes.) (Assist.)	
39125	Fee: \$307.35 Benefit: 75% = \$230.55	
39126	INFUSION PUMP, subcutaneous implantation or replacement of, and connection of the pump to an	

T8. SUF	RGICAL OPERATIONS 7. NEUR	OSURGICAL
	intrathecal or epidural catheter, and filling of reservoir with a therapeutic agent or agents, without programming the pump, for the management of chronic intractable pain (Anaes.) (
	Fee: \$373.20 Benefit: 75% = \$279.90	
	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER, insertion of, for the manachronic intractable pain (Anaes.)	gement of
39127	(See para TN.8.4 of explanatory notes to this Category) Fee: \$488.45 Benefit: 75% = \$366.35	
	INFUSION PUMP, subcutaneous implantation of, AND intrathecal or epidural SPINAL C insertion of, and connection of pump to catheter, and filling of reservoir with a therapeutic agents, with or without programming the pump, for the management of chronic intractable (Assist.)	agent or
39128	Fee: \$680.55 Benefit: 75% = \$510.45	
	EPIDURAL LEAD, percutaneous placement of, including intraoperative test stimulation, in management of chronic intractable neuropathic pain or pain from refractory angina pectori maximum of 4 leads (Anaes.)	
39130	(See para TN.8.4 of explanatory notes to this Category) Fee: \$695.20 Benefit: 75% = \$521.40	
	ELECTRODES, epidural or peripheral nerve, management of patient and adjustment or re- of neurostimulator by a medical practitioner, for the management of chronic intractable ne- or pain from refractory angina pectoris - each day	
39131	Fee: \$131.80 Benefit: 75% = \$98.85 85% = \$112.05	
	Removal of subcutaneously IMPLANTED INFUSION PUMP OR removal or repositionin intrathecal or epidural SPINAL CATHETER, for the management of chronic intractable page 1.	
39133	(See para TN.8.4 of explanatory notes to this Category) Fee: \$164.40 Benefit: 75% = \$123.30	
	NEUROSTIMULATOR or RECEIVER, subcutaneous placement of, including placement connection of extension wires to epidural or peripheral nerve electrodes, for the management intractable neuropathic pain or pain from refractory angina pectoris (Anaes.) (Assist.)	
39134	Fee: \$351.25 Benefit: 75% = \$263.45	
	NEUROSTIMULATOR or RECEIVER, that was inserted for the management of chronic neuropathic pain or pain from refractory angina pectoris, removal of, performed in the ope of a hospital (Anaes.)	
39135	Fee: \$164.40 Benefit: 75% = \$123.30	
	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intrac neuropathic pain or pain from refractory angina pectoris, removal of, performed in the ope of a hospital (Anaes.)	
39136	(See para TN.8.4 of explanatory notes to this Category) Fee: \$164.40 Benefit: 75% = \$123.30	
39137	LEAD, epidural or peripheral nerve that was inserted for the management of chronic intracent neuropathic pain or pain from refractory angina pectoris, surgical repositioning to correct or unsatisfactory positioning, including intraoperative test stimulation, not being a service 39130, 39138 or 39139 applies (Anaes.)	lisplacement

T8. SUF	RGICAL OPERAT	IONS	7. NEUROSURGICAL	
	Fee: \$624.30	Benefit: 75% = \$468.25		
	management of o	NERVE LEAD, surgical placement of, inc chronic intractable neuropathic pain or pair ads (Anaes.) (Assist.)	cluding intraoperative test stimulation, for the in from refractory angina pectoris, to a	
39138	Fee: \$695.20	Benefit: 75% = \$521.40		
	Epidural lead, surgical placement of one or more by partial or total laminectomy, including intraoperative test stimulation, for the management of chronic intractable neuropathic pain or pain refractory angina pectoris—to a maximum of 4 leads (H) (Anaes.) (Assist.)			
39139	Fee: \$933.40	Benefit: 75% = \$700.05		
		THETER, insertion of, under imaging cortion for lysis of adhesions (Anaes.)	ntrol, with epidurogram and epidural	
39140	Fee: \$302.00	Benefit: 75% = \$226.50 85% = \$256.	70	
		PERIPHERAL NE	ERVES	
	CUTANEOUS N (Anaes.) (Assist.		repair of, using microsurgical techniques	
39300	Fee: \$364.40	Benefit: 75% = \$273.30		
	CUTANEOUS N (Anaes.) (Assist.		ry repair of, using microsurgical techniques	
39303	Fee: \$480.65	Benefit: 75% = \$360.50		
	NERVE TRUNK	X, primary repair of, using microsurgical t	echniques (Anaes.) (Assist.)	
39306	Fee: \$697.95	Benefit: 75% = \$523.50		
	NERVE TRUNK	K, secondary repair of, using microsurgica	al techniques (Anaes.) (Assist.)	
39309	Fee: \$736.70	Benefit: 75% = \$552.55		
	NERVE TRUNK	K, (interfascicular), neurolysis of, using m	icrosurgical techniques (Anaes.) (Assist.)	
39312	Fee: \$411.00	Benefit: 75% = \$308.25		
	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgica techniques (Anaes.) (Assist.)		arvesting of nerve graft using microsurgical	
39315	Fee: \$1,062.40	Benefit: 75% = \$796.80		
	CUTANEOUS N (Anaes.) (Assist.	NERVE (including digital nerve), nerve gr	raft to, using microsurgical techniques	
39318	Fee: \$659.20	Benefit: 75% = \$494.40		
	NERVE, transposition of (Anaes.) (Assist.)			
39321	Fee: \$488.45	Benefit: 75% = \$366.35		
	PERCUTANEOUS NEUROTOMY by cryotherapy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.)			
39323	Fee: \$285.45	Benefit: 75% = \$214.10 85% = \$242.	65	
39324	NEURECTOMY	, NEUROTOMY or removal of tumour f	rom superficial peripheral nerve, by open	

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGICAL			
	operation (Anaes.) (Assist.)			
	(See para TN.8.4 of explanatory notes to this Category) Fee: \$285.45 Benefit: 75% = \$214.10 85% = \$242.65			
	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral or cranial nerve, by open operation, not being a service to which item 41575, 41576, 41578 or 41579 applies (Anaes.) (Assist.)			
39327	(See para TN.8.4 of explanatory notes to this Category) Fee: \$488.55 Benefit: 75% = \$366.45			
	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.)			
39330	Fee: \$285.45 Benefit: 75% = \$214.10			
	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.)			
39331	Fee: \$285.45 Benefit: 75% = \$214.10 85% = \$242.65			
	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.)			
39333	Fee: \$411.00 Benefit: 75% = \$308.25 85% = \$349.35			
	CRANIAL NERVES			
	Facio-hypoglossal nerve or facio-accessory nerve, anastomosis of (Anaes.) (Assist.)			
39503	(See para TN.8.166 of explanatory notes to this Category) Fee: \$984.85 Benefit: 75% = \$738.65			
	CRANIO-CEREBRAL INJURIES			
	Any of the following procedures for intracranial haemorrhage or swelling:			
	 (a) craniotomy, craniectomy or burr-holes for removal of intracranial haemorrhage, including stereotaxy; (b) craniotomy or craniectomy for brain swelling, stroke, or raised intracranial pressure, including for subtemporal decompression, including stereotaxy; or (c) post-operative re-opening, including for swelling or post-operative cerebrospinal fluid leak. (Anaes.) (Assist.) 			
39604	Fee: \$1,849.60 Benefit: 75% = \$1387.20			
	Fractured skull, without brain laceration or dural penetration, repair of (Anaes.) (Assist.)			
39610	Fee: \$984.85 Benefit: 75% = \$738.65			
	Fractured skull, with brain laceration or dural penetration but without cerebrospinal fluid, rhinorrhoea or otorrhoea, repair of (Anaes.) (Assist.)			
39612	Fee: \$1,155.50 Benefit: 75% = \$866.65			
	Fractured skull, after trauma, with cerebrospinal fluid rhinorrhoea or otorrhoea, repair of, including stereotaxy and dermofat graft (Anaes.) (Assist.)			
39615	Fee: \$1,971.75 Benefit: 75% = \$1478.85			
	SKULL BASE SURGERY			
39638	Anterior or middle cranial fossa or cavernous sinus, tumour or vascular lesion, removal or radical excision of, including stereotaxy and cranioplasty—conjoint surgery, principal surgeon (Anaes.)			

T8. SUF	RGICAL OPERATIO	NS	7. NEUROSURGICAL
	(Assist.)		
	(See para TN.8.70 of Fee: \$4,390.15	explanatory notes to this Category) Benefit: 75% = \$3292.65	
		cranial fossa or cavernous sinus, tumour or va ng stereotaxy and cranioplasty—conjoint surg	
39639	(See para TN.8.70 of Fee: \$3,508.20	explanatory notes to this Category) Benefit: 75% = \$2631.15	
		cranial fossa or cavernous sinus, tumour or vang stereotaxy and cranioplasty - one surgeon (
39641	(See para TN.8.70 of Fee: \$4,630.50	explanatory notes to this Category) Benefit: 75% = \$3472.90	
		or foramen magnum tumour or vascular lesion and cranioplasty - one surgeon (Anaes.) (As	
39651	(See para TN.8.70 of Fee: \$5,712.85	explanatory notes to this Category) Benefit: 75% = \$4284.65	
		or foramen magnum tumour or vascular lesion and cranioplasty—conjoint surgery, principa	
39654	(See para TN.8.70 of Fee: \$4,390.15	explanatory notes to this Category) Benefit: 75% = \$3292.65	
		or foramen magnum tumour or vascular lesion y and cranioplasty—conjoint surgery, co surge	
39656	(See para TN.8.70 of Fee: \$3,508.20	explanatory notes to this Category) Benefit: 75% = \$2631.15	
		INTRA-CRANIAL NEOPLAS	MS
	Skull tumour, benig	n or malignant, excision of, including stereota	axy and cranioplasty (Anaes.) (Assist.)
39700	Fee: \$1,869.00	Benefit: 75% = \$1401.75	
	Intracranial tumour (a) burr hole and bi (b) drainage of; including stereotax		
39703	Fee: \$1,500.70	Benefit: 75% = \$1125.55	
	Intracranial tumour	one or more, biopsy, drainage, decompression g stereotaxy and cranioplasty (Anaes.) (Assi	
39710	Fee: \$2,499.10	Benefit: 75% = \$1874.35	
	Transcranial tumou (a) meningioma; (b) pinealoma; (c) cranio pharyngi (d) pituitary tumou (e) intraventricular (f) brain stem lesion (g) any other intrac	; lesion; n;	the following:
39712		or without endoscopy), through a single cran	iotomy, including stereotaxy and

T8. SUF	RGICAL OPERATIO	NS 7. NEUROSURGICAL
	cranioplasty (Anae	s.) (Assist.)
	Fee: \$3,817.30	Benefit: 75% = \$2863.00
	Pituitary tumour, r	emoval of, by transphenoidal approach, including stereotaxy and dermis, dermofat or er than a service associated with a service to which item 40600 applies (Anaes.)
39715	Fee: \$2,786.00	Benefit: 75% = \$2089.50
	Arachnoidal cyst,	craniotomy for, including stereotaxy and neuroendoscopy (Anaes.) (Assist.)
39718	Fee: \$1,682.90	Benefit: 75% = \$1262.20
	Awake craniotomy	for functional neurosurgery (Anaes.) (Assist.)
39720	Fee: \$3,571.05	Benefit: 75% = \$2678.30
		CEREBROVASCULAR DISEASE
	Aneurysm, clippin (Anaes.) (Assist.)	g, proximal ligation, or reinforcement of sac, including stereotaxy and cranioplasty
39801	Fee: \$5,712.85	Benefit: 75% = \$4284.65
	Intracranial arteriovenous malformation or fistula, treatment through a craniotomy, including stereota cranioplasty and all angiography (Anaes.) (Assist.)	
39803	Fee: \$5,712.85	Benefit: 75% = \$4284.65
	CAROTID-CAVE (Anaes.) (Assist.)	RNOUS FISTULA, obliteration of - combined cervical and intracranial procedure
39815	Fee: \$1,884.35	Benefit: 75% = \$1413.30 85% = \$1799.65
	Intracranial vascul	ar bypass using indirect techniques, including stereotaxy (Anaes.) (Assist.)
39818	Fee: \$2,500.95	Benefit: 75% = \$1875.75
	Intracranial vascul	ar bypass using direct anastomosis techniques, including stereotaxy (Anaes.) (Assist.)
39821	Fee: \$3,563.35	Benefit: 75% = \$2672.55
	Ventricular, lumba (Assist.)	r or cisternal shunt diversion, insertion or revision of, including stereotaxy (Anaes.)
40004	Fee: \$1,706.15	Benefit: 75% = \$1279.65
		INFECTION
		on, treated by burr hole, including stereotaxy, other than a service associated with a em 40600 applies (Anaes.) (Assist.)
39900	Fee: \$1,500.70	Benefit: 75% = \$1125.55
		on, treated by craniotomy, including stereotaxy, other than a service associated with a em 40600 applies (Anaes.) (Assist.)
39903	Fee: \$2,252.90	Benefit: 75% = \$1689.70
		cull or removal of infected bone flap, craniectomy for, other than a service associated hich item 40600 applies (Anaes.) (Assist.)
39906	(See para TN.8.166	of explanatory notes to this Category)

T8. SUF	RGICAL OPERATI	ONS	7. NEUROSURGICAL	
	Fee: \$822.00	Benefit: 75% = \$616.50		
		CEREBROSPINAL FLUI	D CIRCULATION DISORDERS	
	Endoscopic ventriculostomy for treatment of cerebrospinal fluid circulation disorders, including stereotaxy (Anaes.) (Assist.)		brospinal fluid circulation disorders, including	
40012	Fee: \$1,764.30	Benefit: 75% = \$1323.25		
	LUMBAR CERE	BROSPINAL FLUID DRAIN,	insertion of (Anaes.)	
40018	Fee: \$164.40	Benefit: 75% = \$123.30 85%	6 = \$139.75	
		CONGENIT	TAL DISORDERS	
		ingocele or spinal meningocele, which item 40600 applies (Anae	excision and closure of, other than a service associated s.) (Assist.)	
40104	(See para TN.8.166 Fee: \$1,046.95	of explanatory notes to this Categor Benefit: 75% = \$785.25	ry)	
	Chiari malformat stereotaxy, other	ion, decompression or reconstru than a service associated with a	ction of, including laminectomy, dermofat graft and service to which item 40600 applies (Anaes.) (Assist.)	
40106	Fee: \$2,485.45	Benefit: 75% = \$1864.10		
	Encephalocoele o (Anaes.) (Assist.)	•	and closure of, including stereotaxy and dermofat graft	
40109	Fee: \$1,929.05	Benefit: 75% = \$1446.80		
		rhizolysis, other than a service a	tele or diastematomyelia, multiple levels, including associated with a service to which item 40600 applies	
40112	Fee: \$2,464.15	Benefit: 75% = \$1848.15		
	Craniostenosis, o (Anaes.) (Assist.)		associated with a service to which item 40600 applies	
40119	Fee: \$984.85	Benefit: 75% = \$738.65		
		SKULL RE	CONSTRUCTION	
		651, 39654, 39656, 39700, 3971	associated with a service to which item 39113, 39638, 0, 39712, 39715, 39801, 39803 or 40703 applies	
40600	Fee: \$984.85	Benefit: 75% = \$738.65		
		EF	PILEPSY	
	Corpus callosotomy, for epilepsy, including stereotaxy (Anaes.) (Assist.)			
40700	Fee: \$2,415.70	Benefit: 75% = \$1811.80		
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, subcutaneous placement of electrical pulse generator, for:			
	(a) management of refractory generalised epilepsy; or			
	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery (Anaes.) (Assist.)			
40701	Fee: \$351.25	Benefit: 75% = \$263.45		

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL	
	Vagus nerve stimulation therapy through stimulation of the removal of electrical pulse generator inserted for:	left vagus nerve, surgical repositioning or	
	(a) management of refractory generalised epilepsy; or		
	(b) treatment of refractory focal epilepsy not suitable for res	sective epilepsy surgery (Anaes.) (Assist.)	
40702	Fee: \$164.40 Benefit: 75% = \$123.30		
	Corticectomy, topectomy or partial lobectomy, for epilepsy, (Anaes.) (Assist.)	, including stereotaxy and cranioplasty	
40703	Fee: \$2,499.10 Benefit: 75% = \$1874.35		
	Vagus nerve stimulation therapy through stimulation of the including connection of lead to left vagus nerve and intra-op		
	(a) management of refractory generalised epilepsy; or		
	(b) treatment of refractory focal epilepsy not suitable for res	sective epilepsy surgery (Anaes.) (Assist.)	
40704	Fee: \$695.20 Benefit: 75% = \$521.40		
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical repositioning or removal of lead attached to left vagus nerve for:		
	(a) management of refractory generalised epilepsy; or		
	(b) treatment of refractory focal epilepsy not suitable for res	sective epilepsy surgery (Anaes.) (Assist.)	
40705	Fee: \$624.30 Benefit: 75% = \$468.25		
	Hemispherectomy or functional hemispherectomy, for intractional (Anaes.) (Assist.)	ctable epilepsy, including stereotaxy	
40706	Fee: \$3,571.10 Benefit: 75% = \$2678.35		
	Vagus nerve stimulation therapy through stimulation of the programming of vagus nerve stimulation therapy device using		
	(a) management of refractory generalised epilepsy; or		
	(b) treatment of refractory focal epilepsy not suitable for resective epilepsy surgery		
40707	Fee: \$195.65 Benefit: 75% = \$146.75 85% = \$166.35	5	
	Vagus nerve stimulation therapy through stimulation of the left vagus nerve, surgical replacement of battery in electrical pulse generator inserted for:		
	(a) management of refractory generalised epilepsy; or		
	(b) treating refractory focal epilepsy not suitable for resective	ve epilepsy surgery (Anaes.) (Assist.)	
40708	Fee: \$351.25 Benefit: 75% = \$263.45		
	Intracranial electrode placement by burr hole, including ster	reotaxy (Anaes.) (Assist.)	
40709	Fee: \$1,500.70 Benefit: 75% = \$1125.55		
40712	Intracranial electrode placement by craniotomy, single or m	ultiple, including stereotactic EEG, including	

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGICAL
	stereotaxy (Anaes.) (Assist.)
	Fee: \$3,571.10 Benefit: 75% = \$2678.35
	STEREOTACTIC PROCEDURES
	Functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation, and lesion production, by any method, in the basal ganglia, brain stem or deep white matter tracts, other than a service associated with deep brain stimulation for Parkinson's disease, essential tremor or dystonia (Anaes.) (Assist.)
40801	Fee: \$1,800.35 Benefit: 75% = \$1350.30
	Intracranial stereotactic procedure by any method, other than:
	(a) a service to which item 40801 applies; or
	(b) a service associated with a service to which item 39018, 39109, 39113, 39604, 39615, 39638, 39639, 39641, 39651, 39654, 39656, 39700, 39703, 39710, 39712, 39715, 39718, 39720, 39801, 39803, 39818, 39821, 39900, 39903, 40004, 40012, 40106, 40109, 40700, 40703, 40706, 40709 or 40712 applies (Anaes.) (Assist.)
40803	(See para TN.8.166 of explanatory notes to this Category) Fee: \$1,233.05 Benefit: 75% = \$924.80 85% = \$1148.35
	DEEP BRAIN STIMULATION (unilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of:
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or
	Essential tremor or dystonia where the patient's symptoms cause severe disability (Anaes.) (Assist.)
40850	Fee: \$2,335.20 Benefit: 75% = \$1751.40
	DEEP BRAIN STIMULATION (bilateral) functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes for the treatment of:
	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or
	Essential tremor or dystonia where the patient's symptoms cause severe disability. (Anaes.) (Assist.)
40851	Fee: \$4,086.80 Benefit: 75% = \$3065.10
	DEEP BRAIN STIMULATION (unilateral) subcutaneous placement of neurostimulator receiver or pulse generator for the treatment of:
40852	Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations; or

T8. SUF	RGICAL OPERATIONS	7. NEUROSURGICAL
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.) (Assist.)
	Fee: \$351.25 Benefit: 75% = \$263.45	
	DEEP BRAIN STIMULATION (unilateral) revision or removal of brain e	lectrode for the treatment of:
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40854	Fee: \$542.80 Benefit: 75% = \$407.10	
	DEEP BRAIN STIMULATION (unilateral) removal or replacement of neugenerator for the treatment of:	urostimulator receiver or pulse
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40856	Fee: \$263.45 Benefit: 75% = \$197.60	
	DEEP BRAIN STIMULATION (unilateral) placement, removal or replace the treatment of:	ement of extension lead for
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40858	Fee: \$542.80 Benefit: 75% = \$407.10	
	DEEP BRAIN STIMULATION (unilateral) target localisation incorporating physiological techniques, including intra-operative clinical evaluation, for neurostimulation wire for the treatment of:	
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40860	Fee: \$2,085.90 Benefit: 75% = \$1564.45	
	DEEP BRAIN STIMULATION (unilateral) electronic analysis and prograpulse generator for the treatment of:	mming of neurostimulator
	Parkinson's disease where the patient's response to medical therapy is not s by unacceptable motor fluctuations; or	sustained and is accompanied
	Essential tremor or dystonia where the patient's symptoms cause severe dis	sability. (Anaes.)
40862	Fee: \$195.65 Benefit: 75% = \$146.75 85% = \$166.35	

T8. SUF	RGICAL OPERATIONS 7. NEUROSURGIC	AL
	MISCELLANEOUS	
	Craniotomy, performed by a neurosurgeon in conjunction with the correction of craniofacial abnormalities (Anaes.) (Assist.)	
40905	Fee: \$620.50 Benefit: 75% = \$465.40	
T8. SUF	RGICAL OPERATIONS 8. EAR, NOSE AND THRO	ΑT
	Group T8. Surgical Operations	
	Subgroup 8. Ear, Nose And Throat	
	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes	.)
41500	(See para TN.8.72 of explanatory notes to this Category) Fee: \$85.05 Benefit: 75% = \$63.80 85% = \$72.30	
	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:	
	 a. dysphonia where non stroboscopic techniques of the visualising the larynx have failed to identify any frank abnormality of the vocal folds; or b. benign or malignant vocal fold lesions; or c. premalignant or malignant laryngeal lesions; or d. vocal fold motion impairment or glottal insufficiency; or e. evaluation of vocal fold function after treatment or phonosurgery 	
	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	d
41501	(See para TN.8.76 of explanatory notes to this Category) Fee: \$191.40 Benefit: 75% = \$143.55 85% = \$162.70	
	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.)	
41503	Fee: \$246.25 Benefit: 75% = \$184.70 85% = \$209.35	
	AURAL POLYP, removal of (Anaes.)	
41506	Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25	
	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.)	e
41509	Fee: \$168.05 Benefit: 75% = \$126.05 85% = \$142.85	
	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a servi to which item 41515 applies (Anaes.) (Assist.)	ce
41512	Fee: \$604.20 Benefit: 75% = \$453.15	
	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.) (Assistance of the cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (Anaes.)	t.)
41515	(See para TN.8.73 of explanatory notes to this Category) Fee: \$396.55 Benefit: 75% = \$297.45	

	ONS 8. EAR, NOSE AND THROAT	
EXTERNAL AU	DITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.)	
Fee: \$957.75	Benefit: 75% = \$718.35	
Correction of AU	DITORY CANAL STENOSIS, including meatoplasty, with or without grafting	
(Allaes.) (Assist.)		
Fee: \$1,019.70	Benefit: 75% = \$764.80	
	CION OF EXTERNAL AUDITORY CANAL, being a service associated with a service 557, 41560 and 41563 apply (Anaes.) (Assist.)	
(See para TN.8.74 o Fee: \$294.60	of explanatory notes to this Category) Benefit: 75% = \$220.95	
MYRINGOPLAS	TY, transcanal approach (Rosen incision) (Anaes.) (Assist.)	
Fee: \$605.95	Benefit: 75% = \$454.50	
MYRINGOPLAS	TY, postaural or endaural approach with or without mastoid inspection (Anaes.)	
Fee: \$987.20	Benefit: 75% = \$740.40	
30 Fee: \$987.20 Benefit: 75% = \$740.40 ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Assist.)		
Fee: \$1,180.05	Benefit: 75% = \$885.05	
ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.)		
Fee: \$1,321.75	Benefit: 75% = \$991.35	
OSSICULAR CH	IAIN RECONSTRUCTION (Anaes.) (Assist.)	
Fee: \$1,123.95	Benefit: 75% = \$843.00	
OSSICULAR CH	IAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.)	
Fee: \$1.231.55	Benefit: 75% = \$923.70	
·	MY (CORTICAL) (Anaes.) (Assist.)	
Fee: \$537.55	Benefit: 75% = \$403.20	
	N OF THE MASTOID CAVITY (Anaes.) (Assist.)	
Fee: \$713.35	Benefit: 75% = \$535.05	
	DMY, intact wall technique, with myringoplasty (Anaes.) (Assist.)	
Fee: \$1 642 85	Benefit: 75% = \$1232.15	
	MY, intact wall technique, with myringoplasty and ossicular chain reconstruction	
Fee: \$1,935.60	Benefit: 75% = \$1451.70	
MASTOIDECTO	MY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.)	
Fee: \$1.123.95	Benefit: 75% = \$843.00	
<u> </u>	MY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.)	
Fee: \$1,231.55	Benefit: 75% = \$923.70	
	Fee: \$957.75 Correction of AU (Anaes.) (Assist.) Fee: \$1,019.70 RECONSTRUCT to which items 41 (See para TN.8.74 or Fee: \$294.60 MYRINGOPLAST Fee: \$605.95 MYRINGOPLAST Fee: \$987.20 ATTICOTOMY or (Assist.) Fee: \$1,180.05 ATTICOTOMY or Fee: \$1,321.75 OSSICULAR CHEET Fee: \$1,231.55 MASTOIDECTOR Fee: \$713.35 MASTOIDECTOR Fee: \$1,642.85 MASTOIDECTOR Fee: \$1,935.60 MASTOIDECTOR Fee: \$1,935.60 MASTOIDECTOR Fee: \$1,123.95 MASTOIDECTOR Fee: \$1,935.60 MASTOIDECTOR Fee: \$1,123.95 MASTOIDECTOR Fee: \$1,935.60	

10. 501	GICAL OPERATIONS	8. EAR, NOSE AND THROAT
	MASTOIDECTOMY (RADICAL OR MOI OSSICULAR CHAIN RECONSTRUCTIO	DIFIED RADICAL), MYRINGOPLASTY AND N (Anaes.) (Assist.)
41563	Fee: \$1,524.60 Benefit: 75% = \$1143.4	5
		DIFIED RADICAL), OBLITERATION OF THE MASTOID FERNAL AUDITORY CANAL AND OBLITERATION
41564	Fee: \$1,971.55 Benefit: 75% = \$1478.7	0
	REVISION OF MASTOIDECTOMY (radio (Anaes.) (Assist.)	cal, modified radical or intact wall), including myringoplasty
41566	Fee: \$1,123.95 Benefit: 75% = \$843.00	
	DECOMPRESSION OF FACIAL NERVE	in its mastoid portion (Anaes.) (Assist.)
41569	Fee: \$1,231.55 Benefit: 75% = \$923.70	
	LABYRINTHOTOMY OR DESTRUCTIO	N OF LABYRINTH (Anaes.) (Assist.)
41572	Fee: \$1,065.50 Benefit: 75% = \$799.15	
		UR, removal of by 2 surgeons operating conjointly, by oid approach transmastoid, translabyrinthine or retromastoid ssist.)
41575	Fee: \$2,511.75 Benefit: 75% = \$1883.8	5
		UR, removal of, by transmastoid, translabyrinthine or tree (including aftercare) not being a service to which item
41576	Fee: \$3,767.75 Benefit: 75% = \$2825.8	5
		UR, removal of, by transmastoid, translabyrinthine or are) - conjoint surgery, principal surgeon (Anaes.) (Assist.)
41578	Fee: \$2,511.75 Benefit: 75% = \$1883.8	5
		JR, removal of, by transmastoid, translabyrinthine or ure) - conjoint surgery, co-surgeon (Assist.)
41579	Fee: \$1,883.85 Benefit: 75% = \$1412.9	0
	TUMOUR INVOLVING INFRA-TEMPOR excision of (Anaes.) (Assist.)	RAL FOSSA, removal of, involving craniotomy and radical
41581	Fee: \$2,889.05 Benefit: 75% = \$2166.8	0
	PARTIAL TEMPORAL BONE RESECTION without decompression of facial nerve (Ana	ON for removal of tumour involving mastoidectomy with or es.) (Assist.)
41584	Fee: \$1,982.70 Benefit: 75% = \$1487.0	5
	TOTAL TEMPORAL BONE RESECTION	for removal of tumour (Anaes.) (Assist.)
41587	Fee: \$2,700.40 Benefit: 75% = \$2025.3	0
		OID DECOMPRESSION with or without drainage of

Fee: \$1,231.55			
	Benefit: 75% = \$923.70		
TRANSLABYRI	NTHINE VESTIBULAR NE	RVE SECTION (Anaes.) (Assist.)	
Fee: \$1,605.10	Benefit: 75% = \$1203.85		
RETROLABYRI	NTHINE VESTIBULAR NE	RVE SECTION or COCHLEAR NERVE SECTION, or	
Fee: \$1,793.85	Benefit: 75% = \$1345.40		
		ion by middle cranial fossa approach with cranial nerve	
Fee: \$1,793.85	Benefit: 75% = \$1345.40		
		plantation of titanium fixture for use with implantable ents:	
- With a permar	nent or long term hearing loss	s; and	
- Unable to utili	se conventional air or bone c	onduction hearing aid for medical or audiological reasons;	
- With bone conduction thresholds that accord to recognised criteria for the implantable bone conduction hearing device being inserted.			
Not being a service	ee associated with a service to	o which items 41554, 45794 or 45797 (Anaes.)	
Fee: \$519.60	Benefit: 75% = \$389.70	85% = \$441.70	
OSSEO-INTEGRATION PROCEDURE - fixation of transcutaneous abutment implantation of titanium fixture for use with implantable bone conduction hearing system device, in patients:			
- With a permanent or long term hearing loss; and			
- Unable to utilise conventional air or bone conduction hearing aid for medical or audiological reasons; and			
		rd to recognised criteria for the implantable bone	
Not being a service	ee associated with a service to	o which items 41554, 45794 or 45797 (Anaes.)	
Fee: \$192.35	Benefit: 75% = \$144.30	85% = \$163.50	
STAPEDECTOM			
Fee: \$1,123.95	Benefit: 75% = \$843.00		
<u> </u>			
611 Fee: \$723.20 Benefit: 75% = \$542.40			
+		air of cochleotomy (Anaes.) (Assist.)	
		• • • • • • • • • • • • • • • • • • • •	
OVAL WINDOW	SURGERY, including repair	ir of fistula, not being a service associated with a service	
	BOTH (Anaes.) (A Fee: \$1,793.85 INTERNAL AUE decompression (A Fee: \$1,793.85 OSSEO-INTEGR bone conduction h - With a perman - Unable to utility and - With bone conconduction hearing Not being a service Fee: \$519.60 OSSEO-INTEGR fixture for use with - With a perman - Unable to utility and - With bone conconduction hearing Not being a service Fee: \$192.35 STAPEDECTOM Fee: \$1,123.95 STAPES MOBIL Fee: \$723.20 ROUND WINDOM Fee: \$1,123.95 OVAL WINDOM	RETROLABYRINTHINE VESTIBULAR NEBOTH (Anaes.) (Assist.) Fee: \$1,793.85 Benefit: 75% = \$1345.40 INTERNAL AUDITORY MEATUS, explorate decompression (Anaes.) (Assist.) Fee: \$1,793.85 Benefit: 75% = \$1345.40 OSSEO-INTEGRATION PROCEDURE - impone conduction hearing system device, in pating the pating of the pating system device, in pating the pating of the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. OSSEO-INTEGRATION PROCEDURE - fixed fixture for use with implantable bone conduction. With a permanent or long term hearing loss of the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Not being a service associated with a service to the pating device being inserted. Round being a service associated with a service to the pating device being inserted. Round being a service associated with a service to the pating device being inserted. Round being a service associated with a service to the pating device being inserted. Round being a service associated with a service to the pating device being inserted. Round being a service associated with a service to the pating device being and the pating device being inserted.	

Fee: \$1,954.40 Middle ear implant (a) stable sensorine (b) outer ear pathol (c) a PTA4 of less t (d) bilateral, symmeter other; and (e) speech perception		ia mastoidectomy, for patients with:
Middle ear implant (a) stable sensorine (b) outer ear pathol (c) a PTA4 of less t (d) bilateral, symmeter other; and (e) speech perception	, partially implantable, insertion of, vural hearing loss; and ogy that prevents the use of a conventhan 80 dBHL; and	tional hearing aid; and
Middle ear implant (a) stable sensorine (b) outer ear pathol (c) a PTA4 of less t (d) bilateral, symmeter other; and (e) speech perception	, partially implantable, insertion of, vural hearing loss; and ogy that prevents the use of a conventhan 80 dBHL; and	tional hearing aid; and
(b) outer ear pathol (c) a PTA4 of less t (d) bilateral, symmeteach other; and (e) speech perception	ogy that prevents the use of a conventhan 80 dBHL; and	
(c) a PTA4 of less to (d) bilateral, symmetric each other; and (e) speech perception	han 80 dBHL; and	-
(d) bilateral, symmeach other; and (e) speech perception		lds in both ears within 20 dBHL (0.5-4kHz) of
each other; and (e) speech perception	etrical hearing loss with PTA thresho	lds in both ears within 20 dBHL (0.5-4kHz) of
sound; and	on discrimination of at least 65% corr	rect for word lists with appropriately amplified
(f) a normal middle	ear; and	
(g) normal tympano	ometry; and	
(h) on audiometry,	an air-bone gap of less than 10 dBHI	(0.5-4kHz) across all frequencies; and
(i) no other inner ea	ar disorders	
(Anaes.) (Assist.)		
Fee: \$1,935.60	Benefit: 75% = \$1451.70	
GLOMUS TUMO	JR, transtympanic removal of (Anaes	.) (Assist.)
Fee: \$850.30	Benefit: 75% = \$637.75	
GLOMUS TUMO	JR, transmastoid removal of, includir	ng mastoidectomy (Anaes.) (Assist.)
Fee: \$1,231.55	Benefit: 75% = \$923.70	
ABSCESS OR INF	FLAMMATION OF MIDDLE EAR,	operation for (excluding aftercare) (Anaes.)
(See para TN.8.4 of e	xplanatory notes to this Category)	
		6.25
MIDDLE EAR, EX	XPLORATION OF (Anaes.) (Assist.)	
Fee: \$537.55	Benefit: 75% = \$403.20	
MIDDLE EAR, ins	ertion of tube for DRAINAGE OF (i	ncluding myringotomy) (Anaes.)
Fee: \$246.25	Benefit: 75% = \$184.70 85% = \$20	9.35
		A, CHOLESTEATOMA and POLYP, 1 or more,
with or without my	ringoplasty (Anaes.) (Assist.)	
Fee: \$1,180.05	Benefit: 75% = \$885.05 85% = \$10	95.35
Fee: \$1 472 95	Benefit: 75% = \$1104.75	
	(g) normal tympano (h) on audiometry, (i) no other inner ea (Anaes.) (Assist.) Fee: \$1,935.60 GLOMUS TUMOU Fee: \$850.30 GLOMUS TUMOU Fee: \$1,231.55 ABSCESS OR INF (See para TN.8.4 of e Fee: \$148.50 MIDDLE EAR, EX Fee: \$537.55 MIDDLE EAR, ins Fee: \$246.25 CLEARANCE OF with or without my Fee: \$1,180.05 CLEARANCE OF	(f) a normal middle ear; and (g) normal tympanometry; and (h) on audiometry, an air-bone gap of less than 10 dBHL (i) no other inner ear disorders (Anaes.) (Assist.) Fee: \$1,935.60 Benefit: 75% = \$1451.70 GLOMUS TUMOUR, transtympanic removal of (Anaes Fee: \$850.30 Benefit: 75% = \$637.75 GLOMUS TUMOUR, transmastoid removal of, includin Fee: \$1,231.55 Benefit: 75% = \$923.70 ABSCESS OR INFLAMMATION OF MIDDLE EAR, (See para TN.8.4 of explanatory notes to this Category) Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$12 MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) Fee: \$537.55 Benefit: 75% = \$403.20 MIDDLE EAR, insertion of tube for DRAINAGE OF (inference of the part of the par

T8. SUF	RGICAL OPERAT	IONS	8. EAR, NOSE AND THROAT
	PERFORATION	OF TYMPANUM, cauter	risation or diathermy of (Anaes.)
41641	Fee: \$48.90	Benefit: 75% = \$36.70	85% = \$41.60
	EXCISION OF I		FORATION, not being a service associated with
41644	Fee: \$147.30	Benefit: 75% = \$110.5	0 85% = \$125.25
		equiring use of operating mal anaesthesia (Anaes.)	nicroscope and microinspection of tympanic membrane with
41647	Fee: \$113.30	Benefit: 75% = \$85.00	85% = \$96.35
	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)		
41650	Fee: \$113.30	Benefit: 75% = \$85.00	85% = \$96.35
	POSTNASAL S		r POSTNASAL SPACE, or NASAL CAVITY AND LANAESTHESIA, not being a service associated with a papplies (Anaes.)
41653	Fee: \$74.20	Benefit: 75% = \$55.65	85% = \$63.10
			A, ARREST OF, with posterior nasal packing with or without pack (excluding aftercare) (Anaes.)
41656	(See para TN.8.4 o Fee: \$126.65	of explanatory notes to this Ca Benefit: 75% = \$95.00	
	NOSE, removal	of FOREIGN BODY IN, o	other than by simple probing (Anaes.)
41659	Fee: \$80.00	Benefit: 75% = \$60.00	85% = \$68.00
	NASAL POLYF	OR POLYPI (SIMPLE),	removal of
41662	(See para TN.8.75 Fee: \$85.05	of explanatory notes to this C Benefit: 75% = \$63.80	
	NASAL POLYF	OR POLYPI, removal of	(Anaes.)
41668	(See para TN.8.75 Fee: \$226.80	of explanatory notes to this C Benefit: 75% = \$170.1	
	NASAL SEPTU (Anaes.)	M, SEPTOPLASTY, SUB	MUCOUS RESECTION or closure of septal perforation
41671	(See para TN.8.10 Fee: \$498.35	4 of explanatory notes to this Benefit: 75% = \$373.8	
	NASAL SEPTU	M, reconstruction of (Anae	es.) (Assist.)
41672	Fee: \$621.70	Benefit: 75% = \$466.3	50
	general anaesthe	sia or diathermy of septum	ns) or cauterisation by chemical means when performed under n or turbinates—one or more of these procedures (including er than a service associated with another operation on the
41674	Fee: \$103.65	Benefit: 75% = \$77.75	85% = \$88.15
41677	NASAL HAEM	ORRHAGE, arrest of during	ng an episode of epistaxis by cauterisation or nasal cavity

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	packing or both	(Anaes.)
	Fee: \$92.80	Benefit: 75% = \$69.60 85% = \$78.90
		NASAL ADHESIONS, with or without stenting not being a service associated with any on the nose and not performed during the postoperative period of a nasal operation
41683	Fee: \$120.90	Benefit: 75% = \$90.70 85% = \$102.80
		OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated which another item in this Group applies (Anaes.)
41686	Fee: \$74.20	Benefit: 75% = \$55.65 85% = \$63.10
	TURBINECTO	MY or turbinectomies, partial or total, unilateral (Anaes.)
41689	Fee: \$140.80	Benefit: 75% = \$105.60
	TURBINATES,	submucous resection of, unilateral (Anaes.)
41692	Fee: \$183.60	Benefit: 75% = \$137.70
		ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.)
41698	Fee: \$33.55	Benefit: 75% = \$25.20 85% = \$28.55
	MAXILLARY A	ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission being a service associated with a service to which another item in this Group applies
41701	Fee: \$94.75	Benefit: 75% = \$71.10
		ANTRUM, LAVAGE OF each attendance at which the procedure is performed, sociated consultation (Anaes.)
41704	Fee: \$37.45	Benefit: 75% = \$28.10 85% = \$31.85
	MAXILLARY A	ARTERY, transantral ligation of (Anaes.) (Assist.)
41707	Fee: \$462.60	Benefit: 75% = \$346.95
	ANTROSTOMY	(RADICAL) (Anaes.) (Assist.)
41710	Fee: \$537.55	Benefit: 75% = \$403.20
	ANTROSTOMY (Anaes.) (Assist	(RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy
41713	Fee: \$625.45	Benefit: 75% = \$469.10
	ANTRUM, intra	nasal operation on, or removal of foreign body from (Anaes.) (Assist.)
41716	Fee: \$304.95	Benefit: 75% = \$228.75
		nage of, through tooth socket (Anaes.)
41719	Fee: \$121.25	Benefit: 75% = \$90.95 85% = \$103.10
11/1/		FISTULA, plastic closure of (Anaes.) (Assist.)
41722	Fee: \$605.95	Benefit: 75% = \$454.50 85% = \$521.25
+1/44	T CC. \$000.93	Denotite $1370 - \phi + 3 + 30 = 0370 - \phi 321.23$

T8. SUF	RGICAL OPERATI	ONS	8. EAR, NOSE AND THROAT
	ETHMOIDAL A	RTERY OR ARTERIES, transorbital lig	ation of (unilateral) (Anaes.) (Assist.)
41725	Fee: \$462.60	Benefit: 75% = \$346.95	
	LATERAL RHIN	NOTOMY with removal of tumour (Anae	es.) (Assist.)
41728	Fee: \$925.30	Benefit: 75% = \$694.00	
	DERMOID OF N	IOSE, excision of, with intranasal extens	ion (Anaes.) (Assist.)
41729	Fee: \$586.40	Benefit: 75% = \$439.80	
	FRONTONASA (Assist.)	L ETHMOIDECTOMY by external appro	oach with or without sphenoidectomy (Anaes.)
41731	Fee: \$801.40	Benefit: 75% = \$601.05	
	RADICAL FROM	NTOETHMOIDECTOMY with osteoplast	stic flap (Anaes.) (Assist.)
41734	Fee: \$1,045.70	Benefit: 75% = \$784.30	
	• • • • • • • • • • • • • • • • • • • •	JS, OR ETHMOIDAL SINUSES ON TH	IE ONE SIDE, intranasal operation on
41737	Fee: \$498.35	Benefit: 75% = \$373.80	
	FRONTAL SINU	JS, catheterisation of (Anaes.)	
41740	Fee: \$60.65	Benefit: 75% = \$45.50	
	FRONTAL SINU	JS, trephine of (Anaes.) (Assist.)	
41743	Fee: \$348.00	Benefit: 75% = \$261.00	
	FRONTAL SINU	JS, radical obliteration of (Anaes.) (Assis	st.)
41746	Fee: \$801.40	Benefit: 75% = \$601.05 85% = \$716.	70
	ETHMOIDAL S	NUSES, external operation on (Anaes.)	
41749	Fee: \$625.45	Benefit: 75% = \$469.10	
11715		INUS, intranasal operation on (Anaes.) ((Assist.)
41752	Fee: \$304.95	Benefit: 75% = \$228.75	
41732		TUBE, catheterisation of (Anaes.)	
41755		, ,	
41755	Fee: \$47.95	Benefit: 75% = \$36.00 85% = \$40.80	XAMINATION of NASOPHARYNX and
		r more of these procedures, unilateral or	
41764	Fee: \$126.65	Benefit: 75% = \$95.00 85% = \$107.7	0
		GEAL ANGIOFIBROMA, removal of (A	
41767	Fee: \$760.05	Benefit: 75% = \$570.05 85% = \$675.	35
			copharyngeal myotomy (Anaes.) (Assist.)
41770	Fee: \$723.20	Benefit: 75% = \$542.40	
+1//0			OF (Dohlman's operation) (Anaes.) (Assist.)
41773			(

	RGICAL OPERAT	ONS 8. EAR, NOSE AND THROAT
	Fee: \$605.95	Benefit: 75% = \$454.50
	CRICOPHARY	GEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.)
41776	Fee: \$604.20	Benefit: 75% = \$453.15
	PHARYNGOTO	MY (lateral), with or without total excision of tongue (Anaes.) (Assist.)
41779	Fee: \$723.20	Benefit: 75% = \$542.40
	-	YNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.)
41782	Fee: \$981.85	Benefit: 75% = \$736.40 85% = \$897.15
		YNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.)
41785	Fee: \$1,218.05	Benefit: 75% = \$913.55
	UVULOPALAT (Assist.)	DPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.)
41786	Fee: \$760.05	Benefit: 75% = \$570.05
		AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, onsillectomy, 1 or more stages, including any revision procedures within 12 months
41787	Fee: \$586.40	Benefit: 75% = \$439.80 85% = \$501.70
	examination of t	and adenoids, removal of, in a person aged less than 12 years (including any e postnasal space and nasopharynx and the infiltration of local anaesthetic), not being a tem 41764 applies
	(Anaes.)	
41789	Fee: \$304.95	Benefit: 75% = \$228.75
	Tonsils or tonsils and adenoids, removal of, in a person 12 years of age or over (including any examination of the postnasal space and nasopharynx and the infiltration of local anaesthetic), not being service to which item 41764 applies (Anaes.)	
ļ		tem 41764 applies (Anaes.)
41793	Fee: \$383.10	tem 41764 applies (Anaes.) Benefit: 75% = \$287.35
41793	Fee: \$383.10 TONSILS OR T	
41793 41797	Fee: \$383.10 TONSILS OR T	Benefit: 75% = \$287.35 ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general
	Fee: \$383.10 TONSILS OR T anaesthesia, followard for the followard for the fee: \$148.50 Adenoids, remove the fee: \$148.50	Benefit: 75% = \$287.35 ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general wing removal of (Anaes.)
	Fee: \$383.10 TONSILS OR T anaesthesia, followard for the followard for the fee: \$148.50 Adenoids, remove the fee: \$148.50	Benefit: 75% = \$287.35 ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general wing removal of (Anaes.) Benefit: 75% = \$111.40 al of (including any examination of the postnasal space and nasopharynx and the
41797	Fee: \$383.10 TONSILS OR T anaesthesia, followard for the followar	Benefit: 75% = \$287.35 ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general wing removal of (Anaes.) Benefit: 75% = \$111.40 al of (including any examination of the postnasal space and nasopharynx and the al anaesthetic), not being a service to which item 41764 applies (Anaes.)
41797	Fee: \$383.10 TONSILS OR T anaesthesia, followard for the followar	Benefit: 75% = \$287.35 ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general wing removal of (Anaes.) Benefit: 75% = \$111.40 al of (including any examination of the postnasal space and nasopharynx and the al anaesthetic), not being a service to which item 41764 applies (Anaes.) Benefit: 75% = \$126.05
41797 41801	Fee: \$383.10 TONSILS OR T anaesthesia, followard for the followard for the followard followard for the followard followard for the followard followard for the followard followard followard for the foll	Benefit: 75% = \$287.35 ONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general wing removal of (Anaes.) Benefit: 75% = \$111.40 al of (including any examination of the postnasal space and nasopharynx and the al anaesthetic), not being a service to which item 41764 applies (Anaes.) Benefit: 75% = \$126.05 SIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.)

T8. SUF	RGICAL OPERAT	IONS 8. EAR, NOSE AND THROAT
	UVULOTOMY	or UVULECTOMY (Anaes.)
41810	Fee: \$36.70	Benefit: 75% = \$27.55 85% = \$31.20
	VALLECULAR	OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.)
41813	Fee: \$367.50	Benefit: 75% = \$275.65
	OESOPHAGOS	COPY (with rigid oesophagoscope) (Anaes.)
41816	Fee: \$191.40	Benefit: 75% = \$143.55 85% = \$162.70
	OESOPHAGOS	COPY (with rigid oesophagoscope), with biopsy (Anaes.)
41822	Fee: \$246.25	Benefit: 75% = \$184.70
	OESOPHAGOS	COPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.)
41825	Fee: \$367.50	Benefit: 75% = \$275.65
	OESOPHAGEA	L STRICTURE, dilatation of, without oesophagoscopy (Anaes.)
41828	Fee: \$53.85	Benefit: 75% = \$40.40 85% = \$45.80
	Oesophagus, end	loscopic pneumatic dilatation of, for treatment of achalasia (Anaes.) (Assist.)
41831	Fee: \$368.15	Benefit: 75% = \$276.15 85% = \$312.95
	OESOPHAGUS	, balloon dilatation of, using interventional imaging techniques (Anaes.)
41832	Fee: \$235.65	Benefit: 75% = \$176.75 85% = \$200.35
	LARYNGECTO	MY (TOTAL) (Anaes.) (Assist.)
41834	Fee: \$1,329.45	Benefit: 75% = \$997.10
	VERTICAL HE	MILARYNGECTOMY including tracheostomy (Anaes.) (Assist.)
41837	Fee: \$1,274.70	Benefit: 75% = \$956.05
	SUPRAGLOTT	IC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.)
41840	Fee: \$1,567.25	Benefit: 75% = \$1175.45
		RYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY ryngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.)
41843	Fee: \$1,378.20	Benefit: 75% = \$1033.65
	MICROLARYN	GOSCOPY (Anaes.) (Assist.)
41855	Fee: \$297.20	Benefit: 75% = \$222.90
	MICROLARYN	GOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.)
41858	(See para TN.8.77 Fee: \$509.60	of explanatory notes to this Category) Benefit: 75% = \$382.20
	MICROLARYN (Assist.)	GOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.)
41861	Fee: \$623.15	Benefit: 75% = \$467.40
41064	MICROLARYN	GOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.)
41864		

T8. SUR	RGICAL OPERATIONS		8. EAR, NOSE AND THROAT	
	Fee: \$420.20	Benefit: 75% = \$315.15		
	MICROLARYN	GOSCOPY with arytenoidectomy (A	naes.) (Assist.)	
41867	Fee: \$632.55	Benefit: 75% = \$474.45		
	LARYNGEAL V	VEB, division of, using microlarygoso	copic techniques (Anaes.)	
41868	Fee: \$400.80	Benefit: 75% = \$300.60		
			COLLAGEN OR GELFOAM (Anaes.) (Assist.)	
41870	Fee: \$469.10	Benefit: 75% = \$351.85		
410/0		CTURED, operation for (Anaes.) (As	sist)	
		-		
41873	Fee: \$605.95	Benefit: 75% = \$454.50 85% = \$.		
	(Assist.)	nal operation on, OR LARY NGOFIS.	SURE with or without cordectomy (Anaes.)	
41876	Fee: \$605.95	Benefit: 75% = \$454.50 85% = \$.	521.25	
	LARYNGOPLA	STY or TRACHEOPLASTY, includi	ng tracheostomy (Anaes.) (Assist.)	
41879	Fee: \$981.85	Benefit: 75% = \$736.40		
	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting n to allow insertion of a cuffed tracheostomy tube (Anaes.)			
41880	Fee: \$262.05	Benefit: 75% = \$196.55		
		MY by open exposure of the trachea, yroid isthmus, where performed (Ana	including separation of the strap muscles or nes.) (Assist.)	
41881	Fee: \$414.30	Benefit: 75% = \$310.75		
	CRICOTHYRO	STOMY by direct stab or Seldinger te	chnique, using mini tracheostomy device (Anaes.)	
41884	Fee: \$93.90	Benefit: 75% = \$70.45		
	TRACHE-OESC	PHAGEAL FISTULA, formation of, cluding associated endoscopic proced		
41885	Fee: \$296.90	Benefit: 75% = \$222.70 85% = \$.	252.40	
	TRACHEA, rem	oval of foreign body in (Anaes.)		
41886	Fee: \$183.60	Benefit: 75% = \$137.70 85% = \$	156.10	
11000		PY with dilatation of tracheal strictur		
41904	Fee: \$254.20	Benefit: 75% = \$190.65 85% = \$		
41704		M BUTTON, insertion of (Anaes.)	210.10	
41005			07.70	
41907	Fee: \$126.65	Benefit: 75% = \$95.00 85% = \$100 SALIVARY GLAND, transposition		
		OR SALIVARY GLAND, transposition	on of (Anaes.) (Assist.)	
41910	Fee: \$402.45	Benefit: 75% = \$301.85		
T8. SUR	GICAL OPERAT	IONS	9. OPHTHALMOLO	

T8. SUR	GICAL OPERATIONS 9. OPHTHALMOLOG
	Group T8. Surgical Operations
	Subgroup 9. Ophthalmology
	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.)
42503	Fee: \$105.70 Benefit: 75% = \$79.30
	Glaucoma, implantation of a micro-bypass surgery stent system into the trabecular meshwork, if:
	(a) conservative therapies have failed, are likely to fail, or are contraindicated; and
	(b) the service is performed by a specialist with training that is recognised by the Conjoint Committee for the Recognition of Training in Micro-Bypass Glaucoma Surgery
	(Anaes.)
42504 S	(See para GN.5.16 of explanatory notes to this Category) Fee: \$310.15 Benefit: 75% = \$232.65 Extended Medicare Safety Net Cap: \$46.55
123015	Complete removal from the eye of a trans-trabecular drainage device or devices, with or without replacement, following device related medical complications necessitating complete removal. (Anaes
42505	Fee: \$310.15 Benefit: 75% = \$232.65 85% = \$263.65 Extended Medicare Safety Net Cap: \$46.55
	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.)
42506	Fee: \$496.30 Benefit: 75% = \$372.25 85% = \$421.90
	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.)
42509	Fee: \$628.10 Benefit: 75% = \$471.10
	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.)
42510	Fee: \$724.00 Benefit: 75% = \$543.00
	GLOBE, EVISCERATION OF (Anaes.) (Assist.)
42512	Fee: \$496.30 Benefit: 75% = \$372.25 85% = \$421.90
	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.)
42515	Fee: \$628.10 Benefit: 75% = \$471.10
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayer

T8. SUF	RGICAL OPERATI	ons	9. OPHTHALMOLOGY
	1.	MOVAL OF IMPLANT FROM SOCKET PEG by drilling into an existing orbital im	
	Fee: \$364.40	Benefit: 75% = \$273.30	
		IC SOCKET, treatment of, by insertion of a secondary procedure (Anaes.) (Assist.)	a wired-in conformer, integrated implant or
42521	Fee: \$1,240.80	Benefit: 75% = \$930.60	
	ORBIT, SKIN GI	RAFT TO, as a delayed procedure (Anaes.))
42524	Fee: \$210.95	Benefit: 75% = \$158.25 85% = \$179.35	5
		SOCKET, RECONSTRUCTION INCLUI OULD (Anaes.) (Assist.)	DING MUCOUS MEMBRANE GRAFTING
42527	Fee: \$418.75	Benefit: 75% = \$314.10	
	ORBIT, EXPLO	RATION with or without biopsy, requiring	REMOVAL OF BONE (Anaes.) (Assist.)
42530	Fee: \$651.50	Benefit: 75% = \$488.65	
	ORBIT, EXPLO	RATION OF, with drainage or biopsy not i	requiring removal of bone (Anaes.) (Assist.)
42533	Fee: \$418.75	Benefit: 75% = \$314.10	
	ORBIT, EXENTI transplant (Anaes	ERATION OF, with or without skin graft a .) (Assist.)	and with or without temporalis muscle
42536	Fee: \$860.65	Benefit: 75% = \$645.50	
	ORBIT, EXPLOR (Anaes.) (Assist.)	RATION OF, with removal of tumour or fo	oreign body, requiring removal of bone
42539	Fee: \$1,225.30	Benefit: 75% = \$919.00	
	ORBIT, explorati	on of anterior aspect with removal of tumo	our or foreign body (Anaes.) (Assist.)
42542	Fee: \$519.60	Benefit: 75% = \$389.70	
	ORBIT, explorati	on of retrobulbar aspect with removal of tu	umour or foreign body (Anaes.) (Assist.)
42543	Fee: \$911.45	Benefit: 75% = \$683.60	
		ession of, for dysthyroid eye disease, by fe rbital peribulbar and retrobulbar fat from e	
42545	Fee: \$1,318.30	Benefit: 75% = \$988.75	
	OPTIC NERVE	MENINGES, incision of (Anaes.) (Assist.)	
42548	Fee: \$783.10	Benefit: 75% = \$587.35	
		TING WOUND OR RUPTURE OF, not in of cornea or sclera, or both, not being a ser	nvolving intraocular structures repair vice to which item 42632 applies (Anaes.)
42551	Fee: \$651.50	Benefit: 75% = \$488.65 85% = \$566.80)
42554	EYE, PENETRA repair (Anaes.) (A	TING WOUND OR RUPTURE OF, with assist.)	incarceration or prolapse of uveal tissue

T8. SUI	RGICAL OPERATION	ONS 9. OPHTHALM	9. OPHTHALMOLOGY	
	Fee: \$760.05	Benefit: 75% = \$570.05		
	EYE, PENETRAT (Anaes.) (Assist.)	TING WOUND OR RUPTURE OF, with incarceration of lens or vitreous repart	air	
42557	Fee: \$1,062.40	Benefit: 75% = \$796.80		
	INTRAOCULAR	FOREIGN BODY, removal from anterior segment (Anaes.) (Assist.)		
42563	Fee: \$535.20	Benefit: 75% = \$401.40 85% = \$454.95		
	INTRAOCULAR	FOREIGN BODY, removal from posterior segment (Anaes.) (Assist.)		
42569	Fee: \$1,062.40	Benefit: 75% = \$796.80		
	ORBITAL ABSC	ESS OR CYST, drainage of (Anaes.)		
42572	Fee: \$121.05	Benefit: 75% = \$90.80 85% = \$102.90		
	DERMOID, perior	rbital, excision of, on a person 10 years of age or over (Anaes.)		
42573	Fee: \$234.55	Benefit: 75% = \$175.95 85% = \$199.40		
	DERMOID, orbita	ıl, excision of (Anaes.) (Assist.)		
42574	Fee: \$498.35	Benefit: 75% = \$373.80 85% = \$423.60		
	TARSAL CYST,	extirpation of (Anaes.)		
42575	Fee: \$85.30	Benefit: 75% = \$64.00 85% = \$72.55		
	DERMOID, perior	rbital, excision of, on a person under 10 years of age (Anaes.)		
42576	Fee: \$304.95	Benefit: 75% = \$228.75 85% = \$259.25		
	·	ENTROPION, tarsal cauterisation of (Anaes.)		
42581	Fee: \$121.05	Benefit: 75% = \$90.80 85% = \$102.90		
		Y (Anaes.) (Assist.)		
42584	Fee: \$285.45	Benefit: 75% = \$214.10 85% = \$242.65		
	TRICHIASIS (due each eyelid (Anaes	to causes other than trachoma), treatment of by cryotherapy, laser or electrol	ysis -	
42587	Fee: \$53.60	Benefit: 75% = \$40.20 85% = \$45.60		
	TRICHIASIS (due	to trachoma), treatment of by cryotherapy, laser or electrolysis - each eyelid	(Anaes.)	
42588	Fee: \$53.60	Benefit: 75% = \$40.20 85% = \$45.60		
	CANTHOPLAST	Y, medial or lateral (Anaes.) (Assist.)		
	Fee: \$348.90	Benefit: 75% = \$261.70 85% = \$296.60		
42590	Extended Medica	re Safety Net Cap: \$279.15		
	LACRIMAL GLA	ND, excision of palpebral lobe (Anaes.)		
42593	Fee: \$210.95	Benefit: 75% = \$158.25		
	LACRIMAL SAC	, excision of, or operation on (Anaes.) (Assist.)		
42596	Fee: \$519.60	Benefit: 75% = \$389.70 85% = \$441.70		
42599	LACRIMAL CAN	VALICULAR SYSTEM, establishment of patency by closed operation using s	ilicone	

T8. SUF	GICAL OPERATI	ONS 9. OPHTHALMOLOGY	
	tubes or similar, 1	eye (Anaes.) (Assist.)	
	Fee: \$651.50	Benefit: 75% = \$488.65 85% = \$566.80	
	LACRIMAL CAI (Assist.)	NALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.)	
42602	Fee: \$651.50	Benefit: 75% = \$488.65 85% = \$566.80	
	LACRIMAL CAI	NALICULUS, immediate repair of (Anaes.) (Assist.)	
42605	Fee: \$480.65	Benefit: 75% = \$360.50 85% = \$408.60	
	LACRIMAL DR	AINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.)	
42608	Fee: \$310.15	Benefit: 75% = \$232.65 85% = \$263.65	
		AL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, action, unilateral, with or without lavage - under general anaesthesia (Anaes.)	
42610	Fee: \$99.25	Benefit: 75% = \$74.45 85% = \$84.40	
		L TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing lateral, with or without lavage - under general anaesthesia (Anaes.)	
42611	Fee: \$148.85	Benefit: 75% = \$111.65 85% = \$126.55	
	probing to establi	LTUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, sh patency of the lacrimal passage and/or site of obstruction, unilateral, including a service associated with a service to which item 42610 applies (excluding aftercare)	
42614	(See para TN.8.4 of Fee: \$49.80	explanatory notes to this Category) Benefit: 75% = \$37.35 85% = \$42.35	
	to establish paten	L TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing by of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not sociated with a service to which item 42611 applies (excluding aftercare)	
42615	Fee: \$74.50	Benefit: 75% = \$55.90 85% = \$63.35	
	PUNCTUM SNII	operation (Anaes.)	
42617	Fee: \$141.25	Benefit: 75% = \$105.95 85% = \$120.10	
		usion of, by use of a plug (Anaes.)	
42620	Fee: \$54.30	Benefit: 75% = \$40.75 85% = \$46.20	
		nanent occlusion of, by use of electrical cautery (Anaes.)	
42622	Fee: \$85.30	Benefit: 75% = \$64.00 85% = \$72.55	
12022	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.)		
42623	Fee: \$721.30	Benefit: 75% = \$541.00	
72023		DRHINOSTOMY where a previous dacryocystorhinostomy has been performed	
42626	Fee: \$1,163.30	Benefit: 75% = \$872.50 85% = \$1078.60	
42629		RHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps	

T8. SUF	RGICAL OPERAT	TIONS	9. OPHTHALMOLOGY
	Fee: \$876.25	Benefit: 75% = \$657.20	
	CONJUNCTIV (Anaes.)	AL PERITOMY OR REPAIR OF CORNE	AL LACERATION by conjunctival flap
42632	Fee: \$121.05	Benefit: 75% = \$90.80 85% = \$102.90	
	CORNEAL PE	RFORATIONS, sealing of, with tissue adher	sive (Anaes.) (Assist.)
42635	Fee: \$310.15	Benefit: 75% = \$232.65 85% = \$263.65	5
	CONJUNCTIV	AL GRAFT OVER CORNEA (Anaes.) (Ass	sist.)
42638	Fee: \$387.75	Benefit: 75% = \$290.85 85% = \$329.60	0
	AUTOCONJUN	NCTIVAL TRANSPLANT, or mucous mem	nbrane graft (Anaes.) (Assist.)
42641	Fee: \$504.00	Benefit: 75% = \$378.00 85% = \$428.40	0
		SCLERA, complete removal of embedded for same practitioner (excluding aftercare) (An	oreign body from - not more than once on the naes.)
42644	(See para TN.8.78 Fee: \$74.40	3, TN.8.4 of explanatory notes to this Category) Benefit: 75% = \$55.80 85% = \$63.25	
		ARS, removal of, by partial keratectomy, no 86 applies (Anaes.)	ot being a service associated with a service to
42647	Fee: \$210.95	Benefit: 75% = \$158.25 85% = \$179.35	5
	CORNEA, epith	nelial debridement for corneal ulcer or corne	eal erosion (excluding aftercare) (Anaes.)
42650	(See para TN.8.4 Fee: \$74.40	of explanatory notes to this Category) Benefit: 75% = \$55.80 85% = \$63.25	
	CORNEA, epitl	nelial debridement for eliminating band kera	atopathy (Anaes.)
42651	Fee: \$165.80	Benefit: 75% = \$124.35 85% = \$140.95	5
		n cross linking, on a person with a corneal e er eye. (Anaes.)	ectatic disorder, with evidence of
42652		36 of explanatory notes to this Category) Benefit: 75% = \$928.15 85% = \$1152.8	80
	CORNEA trans	plantation of (Anaes.) (Assist.)	
42653	Fee: \$1,348.60	Benefit: 75% = \$1011.45	
	CORNEA, trans	splantation of, second and subsequent proceed	dures (Anaes.) (Assist.)
42656	Fee: \$1,721.60	Benefit: 75% = \$1291.20	
	SCLERA, trans	plantation of, full thickness, including collect	ction of donor material (Anaes.) (Assist.)
42662	Fee: \$930.50	Benefit: 75% = \$697.90	
	SCLERA, trans (Assist.)	plantation of, superficial or lamellar, includi	ing collection of donor material (Anaes.)
42665	Fee: \$620.45	Benefit: 75% = \$465.35 85% = \$535.75	5
42667	RUNNING CO	RNEAL SUTURE, manipulation of, perform	

T8. SUF	RGICAL OPERA	FIONS 9. OPHTHALMOLOGY
	consultation	
	Fee: \$146.35	Benefit: 75% = \$109.80 85% = \$124.40
	CORNEAL SU operating micro	TURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or scope (Anaes.)
42668	Fee: \$77.65	Benefit: 75% = \$58.25 85% = \$66.05
	CORNEAL ING segment surger procedure (Ana	CISONS, to correct corneal astigmatism of more than $1^{1/2}$ dioptres following anterior y, including appropriate measurements and calculations, performed as an independent es.) (Assist.)
42672	(See para TN.8.7) Fee: \$930.50	9 of explanatory notes to this Category) Benefit: 75% = \$697.90 85% = \$845.80
	including appro	CORNEAL INCISIONS, to correct corneal astigmatism of more than $1^{1}/2$ dioptres, priate measurements and calculations, performed in conjunction with other anterior y (Anaes.) (Assist.)
42673	Fee: \$465.15	Benefit: 75% = \$348.90 85% = \$395.40
	CONJUNCTIV	A, biopsy of, as an independent procedure
42676	Fee: \$119.30	Benefit: 75% = \$89.50 85% = \$101.45
		A, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at tis given including any associated consultation (Anaes.)
42677	Fee: \$62.90	Benefit: 75% = \$47.20 85% = \$53.50
	CONJUNCTIV	A, cryotherapy to, for melanotic lesions or similar using CO ² or N ² 0 (Anaes.)
42680	Fee: \$310.15	Benefit: 75% = \$232.65 85% = \$263.65
	CONJUNCTIV (Anaes.)	AL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility
42683	Fee: \$124.15	Benefit: 75% = \$93.15
	PTERYGIUM,	removal of (Anaes.)
42686	Fee: \$282.20	Benefit: 75% = \$211.65 85% = \$239.90
	PINGUECULA	, removal of, not being a service associated with the fitting of contact lenses (Anaes.)
42689	Fee: \$121.05	Benefit: 75% = \$90.80 85% = \$102.90
		OUR, removal of, excluding Pterygium (Anaes.) (Assist.)
42692	Fee: \$285.45	Benefit: 75% = \$214.10 85% = \$242.65
	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.)	
42695	Fee: \$465.15	Benefit: 75% = \$348.90 85% = \$395.40
	LENS EXTRA	CTION, excluding surgery performed for the correction of refractive error except for greater than 3 dioptres following the removal of cataract in the first eye (Anaes.)
42698	(See para TN.8.8) Fee: \$613.30	0 of explanatory notes to this Category) Benefit: 75% = \$460.00 85% = \$528.60

T8. SUF	RGICAL OPERATION	ONS		9. OPHTHALMOLOGY
				d for the correction of refractive the removal of cataract in the first eye
42701	(See para TN.8.80 o Fee: \$342.05	f explanatory notes to this C Benefit: 75% = \$256.5		
	for the correction		for anisometropia great	ENS, excluding surgery performed er than 3 dioptres following the
42702	Fee: \$784.40 Extended Medica	Benefit: 75% = \$588.3 are Safety Net Cap: \$117		
	INTRAOCULAR the iris or sclera (A		ESIS insertion of, into t	he posterior chamber with fixation to
42703	Fee: \$589.90	Benefit: 75% = \$442.4	5 85% = \$505.20	
		LENS, REMOVAL or Reservice to which item 427		open operation, not being a service
42704	Fee: \$480.65	Benefit: 75% = \$360.5	0 85% = \$408.60	
	for the correction removal of catarac device or devices,	of refractive error except et in the first eye, perform in a patient diagnosed wi	for anisometropia great ned in association with i ith open angle glaucoma	LENS, excluding surgery performed ter than 3 dioptres following the insertion of a trans-trabecular drainage a who is not adequately responsive to coma medication. (Anaes.)
42705	Fee: \$939.60 Extended Medica	Benefit: 75% = \$704.7 are Safety Net Cap: \$140		
	performed for the		rror except for anisomet	ith a different lens, excluding surgery tropia greater than 3 dioptres
42707	Fee: \$822.00	Benefit: 75% = \$616.5	0 85% = \$737.30	
		LENS, removal of, and r iris or sclera (Anaes.) (As	-	inserted into the posterior chamber
42710	Fee: \$930.50	Benefit: 75% = \$697.9	0 85% = \$845.80	
	IRIS SUTURING (Anaes.) (Assist.)	, McCannell technique or	similar, for fixation of	intraocular lens or repair of iris defect
42713	Fee: \$387.75	Benefit: 75% = \$290.8	5 85% = \$329.60	
	CATARACT, JU	VENILE, removal of, incl	luding subsequent need	lings (Anaes.) (Assist.)
42716	Fee: \$1,233.05	Benefit: 75% = \$924.8	0 85% = \$1148.35	
				ERIAL, via a limbal approach, not 02, 42716, 42725 or 42731 applies
42719	Fee: \$535.20	Benefit: 75% = \$401.4	0 85% = \$454.95	
		rs plana sclerotomy, inclu	rding one on more of the	. C. 11

T8. SUF	RGICAL OPERATIONS	9. OPHTHALMOLOGY
	(a) removal of vitreous;	
	(b) division of vitreous bands;	
	(c) removal of epiretinal membranes;	
	(d) capsulotomy (Anaes.) (Assist.)	
	Fee: \$1,380.25 Benefit: 75% = \$1035.20	
	LIMBAL OR PARS PLANA LENSECTOMY combined with vitrectomy with items 42698, 42702, 42719, or 42725 (Anaes.) (Assist.)	y, not being a service associated
42731	Fee: \$1,566.45 Benefit: 75% = \$1174.85	
	Capsulotomy, other than by laser, and other than a service associated with or 42731 applies (Anaes.) (Assist.)	h a service to which item 42725
42734	Fee: \$310.15 Benefit: 75% = \$232.65 85% = \$263.65	
	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVIT therapeutic substances, or the removal of aqueous or vitreous humours for purposes, 1 or more of, as an independent procedure.	
	(See para TN.8.121 of explanatory notes to this Category) Fee: \$310.15 Benefit: 75% = \$232.65 85% = \$263.65	
42738	Extended Medicare Safety Net Cap: \$248.15	
	PARACENTESIS OF ANTERIOR CHAMBER OR VITREOUS CAVIT therapeutic substances, or the removal of aqueous or vitreous humours for purposes, 1 or more of, as an independent procedure, for a patient requiring anaesthetic by a specialist anaesthetist. (Anaes.)	r diagnostic or therapeutic
Amend 42739	(See para TN.8.121 of explanatory notes to this Category) Fee: \$310.15 Benefit: 75% = \$232.65 85% = \$263.65 Extended Medicare Safety Net Cap: \$248.15	
	INTRAVITREAL INJECTION OF THERAPEUTIC SUBSTANCES, or humour for diagnostic purposes, 1 or more of, as a procedure associated (Anaes.)	
42740	(See para TN.8.121 of explanatory notes to this Category) Fee: \$310.15 Benefit: 75% = \$232.65 85% = \$263.65 Extended Medicare Safety Net Cap: \$248.15	
	Posterior juxtascleral depot injection of a therapeutic substance, for the tr neovascularisation due to age-related macular degeneration, 1 or more of	
42741	(See para TN.8.81 of explanatory notes to this Category) Fee: \$310.15 Benefit: 75% = \$232.65 85% = \$263.65	
	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an inde (Assist.)	ependent procedure (Anaes.)
42743	Fee: \$651.50 Benefit: 75% = \$488.65 85% = \$566.80	
	Needle revision of glaucoma filtration bleb, following glaucoma filtering	procedure (Anaes.)
42744	Fee: \$309.95 Benefit: 75% = \$232.50 85% = \$263.50	
42746	GLAUCOMA, filtering operation for, where conservative therapies have	0.11 1 111 1 0.11

T8. SUF	RGICAL OPERATI	ONS 9. OPHTHALMOLOGY			
	contraindicated (A	Anaes.) (Assist.)			
	Fee: \$984.85	Benefit: 75% = \$738.65			
	GLAUCOMA, fi. (Assist.)	ltering operation for, where previous filtering operation has been performed (Anaes.)			
42749	Fee: \$1,233.05	Benefit: 75% = \$924.80			
	GLAUCOMA, in device (Anaes.) (sertion of drainage device incorporating an extraocular reservoir for, such as a Molteno Assist.)			
42752	(See para TN.8.83 (Fee: \$1,380.25	of explanatory notes to this Category) Benefit: 75% = \$1035.20			
	GLAUCOMA, re device (Anaes.)	emoval of drainage device incorporating an extraocular reservoir for, such as a Molteno			
42755	Fee: \$170.60	Benefit: 75% = \$127.95 85% = \$145.05			
		the treatment of primary congenital glaucoma, excluding the minimally invasive laucoma drainage devices (Anaes.) (Assist.)			
42758	Fee: \$721.30	Benefit: 75% = \$541.00			
	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.)				
42761	Fee: \$535.20	Benefit: 75% = \$401.40 85% = \$454.95			
	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.)				
42764	Fee: \$535.20	Benefit: 75% = \$401.40 85% = \$454.95			
	TUMOUR, INVO	DLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.)			
42767	Fee: \$1,124.40	Benefit: 75% = \$843.30			
	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.)				
42770	(See para TN.8.82 o Fee: \$304.00	of explanatory notes to this Category) Benefit: 75% = \$228.00 85% = \$258.40			
		TINA, pneumatic retinopexy for, not being a service associated with a service to which es (Anaes.) (Assist.)			
42773 Fee: \$930.50 Benefit: 75% = \$697.90 85% = \$845.80		Benefit: 75% = \$697.90 85% = \$845.80			
	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.)				
42776	Fee: \$1,380.25	Benefit: 75% = \$1035.20			
	DETACHED RE	TINA, revision of scleral buckling operation for (Anaes.) (Assist.)			
42779	Fee: \$1,721.60	Benefit: 75% = \$1291.20			
	LASER TRABEC	CULOPLASTY, for the treatment of glaucoma. Each treatment to 1 eye, to a maximum of that eye in a 2 year period (Anaes.) (Assist.)			
42782	(See para TN 8 84	of explanatory notes to this Category)			

T8. SUF	RGICAL OPERAT	TONS	9. OPHTHALMOLOGY	
	Fee: \$465.15	Benefit: 75% = \$348.90	0 85% = \$395.40	
	LASER IRIDOT year period (Ana	-	sode to 1 eye, to a maximum of 3 treatments to that eye in a 2	
42785	(See para TN.8.85 Fee: \$364.40	of explanatory notes to this C Benefit: 75% = \$273.30		
			e to one eye, to a maximum of 2 treatments to that eye in a 2 d with a service to which item 42702 applies (Anaes.)	
42788	(See para TN.8.86 Fee: \$364.40	of explanatory notes to this C Benefit: 75% = \$273.30		
		each treatment to one eye,	erial 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 Fee: \$364.40	of explanatory notes to this C Benefit: 75% = \$273.30		
		SUTURE BY LASER follor treatments to that eye in a	wing glaucoma filtration surgery, each treatment to 1 eye, to 2 year period (Anaes.)	
42794	(See para TN.8.88 Fee: \$69.80	of explanatory notes to this C Benefit: 75% = \$52.35		
		RADIOACTIVE PLAQUE omas, insertion of (Anaes.)	(Ruthenium 106 or Iodine 125), for the treatment of (Assist.)	
42801	Fee: \$1,082.50	Benefit: 75% = \$811.90	0	
		RADIOACTIVE PLAQUE omas, removal of (Anaes.)	(Ruthenium 106 or Iodine 125), for the treatment of (Assist.)	
42802	Fee: \$541.10	Benefit: 75% = \$405.85	5	
			on to the sclera to localise the tumour base to assist in nomas, 1 or more (Anaes.) (Assist.)	
42805	Fee: \$604.85	Benefit: 75% = \$453.65	5 85% = \$520.15	
	IRIS TUMOUR	, laser photocoagulation of	(Anaes.) (Assist.)	
42806	Fee: \$364.40	Benefit: 75% = \$273.30	0 85% = \$309.75	
	PHOTOMYDRIASIS, laser			
42807	Fee: \$366.90	Benefit: 75% = \$275.20	0 85% = \$311.90	
	Laser peripheral iridoplasty			
42808	Fee: \$366.90 Benefit: 75% = \$275.20 85% = \$311.90		0 85% = \$311.90	
		coagulation of, not being a	service associated with photodynamic therapy with	
42809	Fee: \$465.15	Benefit: 75% = \$348.90	0 85% = \$395.40	
42810		PEUTIC KERATECTOM	Y, by laser, for corneal scarring or disease, excluding surgery	

T8. SUF	RGICAL OPERAT	TIONS	9. OPHTHALMOLOGY
	Fee: \$585.45	Benefit: 75% = \$439.10	85% = \$500.75
	TRANSPUPILL malformations (Y, for treatment of choroidal and retinal tumours or vascular
42811	Fee: \$465.15	Benefit: 75% = \$348.90	85% = \$395.40
	Removal of scle (Anaes.)	ral buckling material, from	an eye having undergone previous scleral buckling surgery
42812	Fee: \$170.60	Benefit: 75% = \$127.95	5 85% = \$145.05
			oil or other liquid vitreous substitutes from, during a ous substitute is inserted (Anaes.) (Assist.)
42815	Fee: \$651.50	Benefit: 75% = \$488.65	5
	RETINA, CRYO item 42809 or 42		ependent procedure, or when performed in conjunction with
42818	Fee: \$604.85	Benefit: 75% = \$453.65	5 85% = \$520.15
	OCULAR TRAI	NSILLUMINATION, for th	ne diagnosis and measurement of intraocular tumours
42821	Fee: \$93.20	Benefit: 75% = \$69.90	85% = \$79.25
	RETROBULBA	R INJECTION OF ALCO	HOL OR OTHER DRUG, as an independent procedure
42824	Fee: \$72.05	Benefit: 75% = \$54.05	85% = \$61.25
		ATION FOR, ON 1 OR Bo patient aged 15 years or ov	OTH EYES, the operation involving a total of 1 OR 2 ver (Anaes.) (Assist.)
42833	Fee: \$604.85	Benefit: 75% = \$453.65	5
	MUSCLES, on a	a patient aged 14 years or u	OTH EYES, the operation involving a total of 1 OR 2 nder, or where the patient has had previous squint, retinal or or on a patient with concurrent thyroid eye disease (Anaes.)
42836	Fee: \$752.20	Benefit: 75% = \$564.15	5
	-	ATION FOR, ON 1 OR Bo patient aged 15 years or ov	OTH EYES, the operation involving a total of 3 OR MORE ver (Anaes.) (Assist.)
42839	Fee: \$721.30	Benefit: 75% = \$541.00	
	MUSCLES, on a	a patient aged 14 years or u	OTH EYES, the operation involving a total of 3 or MORE nder, or where the patient has had previous squint, retinal or or on a patient with concurrent thyroid eye disease (Anaes.)
42842	Fee: \$899.55	Benefit: 75% = \$674.70)
		NT OF ADJUSTABLE SU eration for correction of squ	TURES, 1 or both eyes, as an independent procedure int (Anaes.)
42845	(See para TN.8.89 Fee: \$195.35	of explanatory notes to this C Benefit: 75% = \$146.55	
42848	SQUINT, muscl	e transplant for (Hummelsh	eim type, or similar operation) on a patient aged 15 years or

T8. SUR	RGICAL OPERAT	IONS 9. OPHTHALMOLOGY	
	over (Anaes.) (A	ssist.)	
	Fee: \$721.30	Benefit: 75% = \$541.00	
	under, or where	e transplant for (Hummelsheim type, or similar operation) on a patient aged 14 years or the patient has had previous squint, retinal or extra ocular operations on the eye or eyes, with concurrent thyroid eye disease (Anaes.) (Assist.)	
42851	Fee: \$899.55	Benefit: 75% = \$674.70	
	RUPTURED MI (Anaes.) (Assist	EDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of	
42854	Fee: \$418.75	Benefit: 75% = \$314.10 85% = \$355.95	
		OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without upsed iris (Anaes.) (Assist.)	
42857	Fee: \$418.75	Benefit: 75% = \$314.10 85% = \$355.95	
	EYELID (upper retractors (Anaes	or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid s.) (Assist.)	
42860	Fee: \$930.50	Benefit: 75% = \$697.90 85% = \$845.80	
	EYELID, recession of (Anaes.) (Assist.)		
42863	Fee: \$798.75	Benefit: 75% = \$599.10 85% = \$714.05	
	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes.) (Assist.)		
42866	Fee: \$775.35	Benefit: 75% = \$581.55 85% = \$690.65	
	EYELID closure	in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.)	
42869	Fee: \$566.15	Benefit: 75% = \$424.65 85% = \$481.45	
		vation of, by skin excision, to correct for a reduced field of vision caused by paretic, traumatic eyebrow descent/ptosis to a position below the superior orbital rim (Anaes.)	
42872	Fee: \$248.20	Benefit: 75% = \$186.15 85% = \$211.00	
	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: \$469.30	Benefit: 75% = \$352.00 85% = \$398.95	
		nerapy, both eyes, including the infusion of Verteporfin continuously through a using a non-thermal laser at a wavelength of 689nm, for the treatment of choroidal on.	
43022	Fee: \$563.20	Benefit: 75% = \$422.40 85% = \$478.75	
		eporfin for discontinued photodynamic therapy, where a session of therapy which would ded under item 43021 or 43022 has been discontinued on medical grounds.	
43023	Fee: \$91.25	Benefit: 75% = \$68.45 85% = \$77.60	
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T8. SUF	RGICAL OPERATIONS 10. OPERATIONS FOR OSTEOMYELITIS
	Group T8. Surgical Operations
	Subgroup 10. Operations For Osteomyelitis
	ACUTE
	OPERATION ON PHALANX (Anaes.)
43500	Fee: \$127.20 Benefit: 75% = \$95.40
	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.)
43503	Fee: \$211.10 Benefit: 75% = \$158.35
	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)
43506	Fee: \$367.50 Benefit: 75% = \$275.65
	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)
43509	Fee: \$367.50 Benefit: 75% = \$275.65
	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	Fee: \$367.50 Benefit: 75% = \$275.65
	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.)
43515	Fee: \$367.50 Benefit: 75% = \$275.65 85% = \$312.40
	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.)
43518	Fee: \$605.95 Benefit: 75% = \$454.50
	OPERATION ON SKULL (Anaes.) (Assist.)
43521	Fee: \$479.05 Benefit: 75% = \$359.30
	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (Anaes.) (Assist.)
43524	Fee: \$605.95 Benefit: 75% = \$454.50 85% = \$521.25
T8. SUF	RGICAL 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.)
43801	Fee: \$987.20 Benefit: 75% = \$740.40

T8. SUF	RGICAL OPERATION	ONS 11. PAEDIATRIC	
		ALROTATION with or without volvulus, laparotomy for, with bowel resection and	
	anastomosis, with	or without formation of stoma (Anaes.) (Assist.)	
43804	Fee: \$1,051.10	Benefit: 75% = \$788.35	
	UMBILICAL, EF (Anaes.)	IGASTRIC OR LINEA ALBA HERNIA, repair of, on a person under 10 years of age	
43805	Fee: \$367.50	Benefit: 75% = \$275.65	
	DUODENAL AT (Assist.)	RESIA or STENOSIS, duodenoduodenostomy or duodenojejunostomy for (Anaes.)	
43807	Fee: \$1,146.75	Benefit: 75% = \$860.10	
	JEJUNAL ATRE	SIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.)	
43810	Fee: \$1,337.85	Benefit: 75% = \$1003.40	
		EUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intesinal r without meconium peritonitis (Anaes.) (Assist.)	
43813	Fee: \$1,337.85	Benefit: 75% = \$1003.40	
		, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with	
	a service to which	item 43813 applies, laparotomy for (Anaes.) (Assist.)	
43816	Fee: \$1,242.20	Benefit: 75% = \$931.65	
	Agangliosis Coli, (Anaes.) (Assist.)	laparotomy for, with or without frozen section biopsies and formation of stoma	
43819	Fee: \$1,003.35	Benefit: 75% = \$752.55	
	ANORECTAL M	ALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.)	
43822	Fee: \$1,003.35	Benefit: 75% = \$752.55	
		IMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other oup applies (Anaes.) (Assist.)	
43825	Fee: \$1,146.75	Benefit: 75% = \$860.10	
	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.)		
43828	Fee: \$1,266.90	Benefit: 75% = \$950.20	
	ACUTE NEONA laparotomy for (A	TAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, naes.) (Assist.)	
43831	Fee: \$987.20	Benefit: 75% = \$740.40	
	BRANCHIAL FI	STULA, on a person under 10 years of age. Removal of, (Anaes.) (Assist.)	
43832	Fee: \$673.35	Benefit: 75% = \$505.05	
	+	TION for necrotising enterocolitis stricture or strictures, including any anastomoses or	
43834	Fee: \$1,146.75	Benefit: 75% = \$860.10	
43835	<u> </u>	ED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel	

8. SURGI	CAL OPERATION	DNS 11. PAEDIATRIC	
1	resection, on a per	son under 10 years of age (Anaes.) (Assist.)	
	Fee: \$698.85	Benefit: 75% = \$524.15	
(CONGENITAL D	IAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with ed in the first 24 hours of life (Anaes.) (Assist.)	
3837	Fee: \$1,433.35	Benefit: 75% = \$1075.05	
		rnia, 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.)	
3838	Fee: \$1,283.35	Benefit: 75% = \$962.55	
		IAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed of life and before 20 days of age (Anaes.) (Assist.)	
3840	Fee: \$1,242.20	Benefit: 75% = \$931.65	
		NGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to or 43835 applies, on a person under 10 years of age (Anaes.) (Assist.)	
3841	Fee: \$622.70	Benefit: 75% = \$467.05	
		ATRESIA (with or without repair of tracheo-oesophageal fistula), complete being a service to which item 43846 applies (Anaes.) (Assist.)	
3843	Fee: \$1,911.25	Benefit: 75% = \$1433.45	
		ATRESIA (with or without repair of tracheo-oesophageal fistula), complete fant of birth weight less than 1500 grams (Anaes.) (Assist.)	
3846	Fee: \$2,054.55	Benefit: 75% = \$1540.95	
,	OESOPHAGEAL	ATRESIA, gastrostomy for (Anaes.) (Assist.)	
3849	Fee: \$525.55	Benefit: 75% = \$394.20	
	OESOPHAGEAL anastomosis (Anae	ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without es.) (Assist.)	
3852	Fee: \$1,672.20	Benefit: 75% = \$1254.15	
	OESOPHAGEAL	ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.)	
3855	Fee: \$1,767.95	Benefit: 75% = \$1326.00	
	OESOPHAGEAL	ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.)	
3858	Fee: \$621.10	Benefit: 75% = \$465.85	
(CONGENITAL C	YSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR noracotomy and lung resection for (Anaes.) (Assist.)	
3861	Fee: \$1,720.15	Benefit: 75% = \$1290.15	
(GASTROSCHISIS	S, operation for (Anaes.) (Assist.)	
3864	Fee: \$1,290.10	Benefit: 75% = \$967.60	
-	GASTROSCHISIS or Exomphalos, secondary operation for, with removal of silo (Anaes.) (Assist.)		
3867	Fee: \$716.70	Benefit: 75% = \$537.55	
(·		

T8. SUF	RGICAL OPERATI	ONS 11.	PAEDIATRIC
	EXOMPHALOS	containing small bowel only, operation for (Anaes.) (Assist.)	
43870	Fee: \$1,003.35	Benefit: 75% = \$752.55	
	EXOMPHALOS	containing small bowel and other viscera, operation for (Anaes.) (Assist	t.)
43873	Fee: \$1,337.85	Benefit: 75% = \$1003.40	
43073	· ·	GEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assis	st.)
43876	Fee: \$1,146.75	Benefit: 75% = \$860.10	,
43070		GEAL TERATOMA, excision of, by combined posterior and abdominal	Lannroach
	(Anaes.) (Assist.)	· · · · · · · · · · · · · · · · · · ·	парргоасп
43879	Fee: \$1,337.85	Benefit: 75% = \$1003.40	
		TROPHY, operation for (Anaes.) (Assist.)	
43882	Fee: \$1,720.15	Benefit: 75% = \$1290.15 85% = \$1635.45	
13002	τ εε. φ1,720.13	THORACIC SURGERY	
	TRACHEO-OES	OPHAGEAL FISTULA without atresia, division and repair of (Anaes.)	(Assist.)
43900	Fee: \$1,146.75	Benefit: 75% = \$860.10	
,00	· · · · · · · · · · · · · · · · · · ·	L ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesopha	geal
		utilizing gastric tube, jejunum or colon (Anaes.) (Assist.)	
43903	Fee: \$1,911.25	Benefit: 75% = \$1433.45	
		resection of congenital, anastomic or corrosive stricture and anastomosi	is, not being a
	service to which i	item 43903 applies (Anaes.) (Assist.)	
43906	Fee: \$1,672.20	Benefit: 75% = \$1254.15	
	TRACHEOMAL	ACIA, aortopexy for (Anaes.) (Assist.)	
43909	Fee: \$1,672.20	Benefit: 75% = \$1254.15	
		IY and excision of 1 or more of bronchogenic or enterogenous cyst or more	ediastinal
	teratoma (Anaes.)	(Assist.)	
43912	Fee: \$1,579.85	Benefit: 75% = \$1184.90	
	EVENTRATION	I, plication of diaphragm for (Anaes.) (Assist.)	
43915	Fee: \$1,194.50	Benefit: 75% = \$895.90	
		ABDOMINAL SURGERY	
	HYPERTROPHI	C PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.)	
43930	Fee: \$459.35	Benefit: 75% = \$344.55	
	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.)		
43933	Fee: \$537.70	Benefit: 75% = \$403.30	
		ΓΙΟΝ, laparotomy and resection with anastomosis (Anaes.) (Assist.)	
43936	Fee: \$1,003.35	Benefit: 75% = \$752.55	
43939		NIA following neonatal closure of exomphalos or gastroschisis, repair o	of (Anaes)
.5/5/	, E. , I IV IE IIEK	The state of the s	1 (1 111000.)

T8. SUF	RGICAL OPERAT	IONS 11. PAEDIATRIC			
	(Assist.)				
	Fee: \$764.45	Benefit: 75% = \$573.35			
		WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.)			
12012					
43942	Fee: \$238.95	Benefit: 75% = \$179.25 LLO INTESTINAL DUCT, excision of (Anaes.) (Assist.)			
	FAILMI VIILI				
43945	Fee: \$1,003.35	Benefit: 75% = \$752.55			
	UMBILICAL G	RANULOMA, excision of, under general anaesthesia (Anaes.)			
43948	Fee: \$143.45	Benefit: 75% = \$107.60			
		PHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for,			
	without gastrosto	omy (Anaes.) (Assist.)			
43951	Fee: \$898.55	Benefit: 75% = \$673.95			
		DPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for,			
	with gastrostomy	y (Anaes.) (Assist.)			
43954	Fee: \$1,099.05	Benefit: 75% = \$824.30			
		GASTRO-OESOPHAGEAL REFLUX, LAPAROTOMY AND FUNDOPLICATION for, with or			
	without matus ne	ernia, in child with neurological disease, with gastrostomy (Anaes.) (Assist.)			
43957	Fee: \$1,194.50	Benefit: 75% = \$895.90			
	ANORECTAL N	MALFORMATION, perineal anoplasty of (Anaes.) (Assist.)			
43960	Fee: \$420.20	Benefit: 75% = \$315.15			
	ANORECTAL N	MALFORMATION, posterior sagittal anorectoplasty of (Anaes.) (Assist.)			
43963	Fee: \$1,672.20	Benefit: 75% = \$1254.15			
		MALFORMATION, posterior sagittal anorectoplasty of, with laparotomy (Anaes.)			
	(Assist.)				
43966	Fee: \$1,911.25	Benefit: 75% = \$1433.45			
	PERSISTENT CLOACA, total correction of, with genital repair using posterior sagittal approach, with				
	or without lapare	otomy (Anaes.) (Assist.)			
43969	Fee: \$2,627.95	Benefit: 75% = \$1971.00			
	CHOLEDOCHA	AL CYST, resection of, with 1 duct anastomosis (Anaes.) (Assist.)			
43972	Fee: \$1,911.25	Benefit: 75% = \$1433.45			
13772		AL CYST, resection of, with 2 duct anastomoses (Anaes.) (Assist.)			
42055					
43975	Fee: \$2,245.75	Benefit: 75% = \$1684.35			
	DILIAK I AIRI	ESIA, portoenterostomy for (Anaes.) (Assist.)			
43978	Fee: \$1,911.25	Benefit: 75% = \$1433.45			
43981		TOMA, NEUROBLASTOMA OR OTHER MALIGNANT TUMOUR, laparotomy cluding associated biopsies, where no other intra-abdominal procedure is performed			
43961	(exploratory), in	Juding associated biopsies, where no other intra-abdominal procedure is performed			

T8. SUF	RGICAL OPERATION	DNS 11. PAEDIATRIC	
	(Anaes.) (Assist.)		
	Fee: \$525.55	Benefit: 75% = \$394.20	
	NEPHROBLASTO	DMA, radical nephrectomy for (Anaes.) (Assist.)	
43984	Fee: \$1,337.85	Benefit: 75% = \$1003.40	
	NEUROBLASTO	MA, radical excision of (Anaes.) (Assist.)	
43987	Fee: \$1,481.30	Benefit: 75% = \$1111.00	
		i, definitive resection with pull-through anastomosis, with or without frozen section inglionic segment extends to sigmoid colon (Anaes.) (Assist.)	
43990	Fee: \$1,815.75	Benefit: 75% = \$1361.85	
		i, definitive resection with pull-through anastomosis, with or without frozen section inglionic segment extends into descending or transverse colon with or without resiting (Assist.)	
43993	Fee: \$1,959.00	Benefit: 75% = \$1469.25	
		i, total colectomy for total colonic aganglionosis with ileoanal pull-through, with or e ileocolic anastomosis (Anaes.) (Assist.)	
43996	Fee: \$2,197.95	Benefit: 75% = \$1648.50	
	Aganglionosis Col	i, anal sphincterotomy as an independent procedure for (Anaes.) (Assist.)	
43999	Fee: \$274.85	Benefit: 75% = \$206.15	
	RECTUM, examination of, on a person under 2 years of age, under general anaesthesia with full thickness biopsy or removal of polyp or similar lesion (Anaes.) (Assist.)		
44101	Fee: \$344.50	Benefit: 75% = \$258.40	
		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: \$264.95	Benefit: 75% = \$198.75	
	RECTAL PROLA under general anae	PSE, SUBMUCOSAL or perirectal injection for, on a person under 2 years of age, sthesia (Anaes.)	
44104	Fee: \$60.50	Benefit: 75% = \$45.40 85% = \$51.45	
	RECTAL PROLAPSE, SUBMUCOSAL or perirectal injection for, on a person 2 years of age or over, under general anaesthesia (Anaes.)		
44105	Fee: \$46.50	Benefit: 75% = \$34.90 85% = \$39.55	
	INGUINAL HERN	NIA repair at age less than 12 months (Anaes.) (Assist.)	
44108	Fee: \$506.80	Benefit: 75% = \$380.10	
	OBSTRUCTED OR STRANGULATED INGUINAL HERNIA, repair, at age, less than 12 months including orchidopexy when performed (Anaes.) (Assist.)		
44111	Fee: \$593.60	Benefit: 75% = \$445.20 85% = \$508.90	
44114	INGUINAL HERN (Assist.)	NIA repair at age less than 12 months when orchidopexy also required (Anaes.)	

T8. SUI	RGICAL OPERAT	IONS 11. PAEDIATRIC
	Fee: \$593.60	Benefit: 75% = \$445.20
		MISCELLANEOUS SURGERY
	LYMPHADENE (Assist.)	ECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.)
44130	Fee: \$477.75	Benefit: 75% = \$358.35 85% = \$406.10
	TORTICOLLIS,	open division of sternomastoid muscle for (Anaes.) (Assist.)
44133	Fee: \$379.25	Benefit: 75% = \$284.45
	INGROWN TO	E NAIL, operation for, under general anaesthesia (Anaes.)
44136	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60
T8. SUF	RGICAL OPERAT	IONS 12. AMPUTATIONS
	Group T8. Surg	ical Operations
		Subgroup 12. Amputations
	HAND, MIDCA	RPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.)
44325	Fee: \$304.95	Benefit: 75% = \$228.75 85% = \$259.25
	HAND, FOREA	RM OR THROUGH ARM, amputation of (Anaes.) (Assist.)
44328	Fee: \$367.50	Benefit: 75% = \$275.65
	AMPUTATION	AT SHOULDER (Anaes.) (Assist.)
44331	Fee: \$605.95	Benefit: 75% = \$454.50
	INTERSCAPUL	OTHORACIC AMPUTATION (Anaes.) (Assist.)
44334	Fee: \$1,231.55	Benefit: 75% = \$923.70 85% = \$1146.85
	1 DIGIT of foot,	amputation of (Anaes.)
44338	Fee: \$148.50	Benefit: 75% = \$111.40 85% = \$126.25
	2 DIGITS of 1 fo	oot, amputation of (Anaes.)
44342	Fee: \$226.80	Benefit: 75% = \$170.10
	3 DIGITS of 1 fo	oot, amputation of (Anaes.) (Assist.)
44346	Fee: \$261.90	Benefit: 75% = \$196.45
		oot, amputation of (Anaes.) (Assist.)
44350	Fee: \$297.20	Benefit: 75% = \$222.90 85% = \$252.65
	5 DIGITS of 1 fo	oot, amputation of (Anaes.) (Assist.)
44354	Fee: \$340.15	Benefit: 75% = \$255.15
	TOE, including 1	metatarsal or part of metatarsal each toe, amputation of (Anaes.)
44358	Fee: \$189.65	Benefit: 75% = \$142.25
		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	IONS 12. AMPUTATIONS	
	(Anaes.) (Assist)	
	Fee: \$272.15	Benefit: 75% = \$204.15	
	FOOT AT ANK	LE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.)	
44361	Fee: \$367.50	Benefit: 75% = \$275.65	
	FOOT, MIDTA	RSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.)	
44364	Fee: \$304.95	Benefit: 75% = \$228.75	
	AMPUTATION	THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.)	
44367	Fee: \$538.25	Benefit: 75% = \$403.70	
	AMPUTATION	AT HIP (Anaes.) (Assist.)	
44370	Fee: \$742.70	Benefit: 75% = \$557.05	
		R, amputation of (Anaes.) (Assist.)	
44373	Fee: \$1,524.60	Benefit: 75% = \$1143.45 85% = \$1439.90	
	·	STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.)	
44376	Derived Fee: 75	% of the original amputation fee	
	RGICAL OPERAT		
101001			
	Group T8. Surg	ical Operations	
	Subgroup 13. Plastic And Reconstructive Surgery		
	GENERAL		
		al muscle flap repair, on eyelid, nose, lip, neck, hand, thumb, finger or genitals not in any of items 31356 to 31376 (Anaes.)	
45000	Fee: \$558.25	Benefit: 75% = \$418.70 85% = \$474.55	
		al myocutaneous flap repair to one defect, simple and small not in association with any o 31376 (Anaes.)	
45003	Fee: \$620.45 Extended Medi	Benefit: 75% = \$465.35 85% = \$535.75 care Safety Net Cap: \$496.40	
		E LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus large muscle) (Anaes.) (Assist.)	
45006	Fee: \$1,070.05	Benefit: 75% = \$802.55	
	SINGLE STAGE	E LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.)	
45009	Fee: \$390.90	Benefit: 75% = \$293.20	
		E LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, ar large muscle) (Anaes.) (Assist.)	
45012	Fee: \$654.85	Benefit: 75% = \$491.15	
45015		IYOCUTANEOUS FLAP, delay of (Anaes.)	

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$310.15 Benefit: 75% = \$232.65		
	Dermis, dermofat or fascia graft (other than tra	ansfer of fat by injection):	
	(a) if the service is not associated with neurosi items 51011 to 51171; and	urgical services for spinal disorders mentioned in any of	
	(b) other than a service associated with a servi (Anaes.) (Assist.)	ce to which item 39615, 39715, 40106 or 40109 applies	
45018	Fee: \$488.45 Benefit: 75% = \$366.35	85% = \$415.20	
	Full face chemical peel for severely sun-dama	ged skin, if:	
	(a) the damage affects at least 75% of the facial	al skin surface area; and	
	(b) the damage involves photo-damage (derma	atoheliosis); and	
	(c) the photo-damage involves:		
	(i) a solar keratosis load exceeding 30 in	dividual lesions; or	
	(ii) solar lentigines; or		
	(iii) freckling, yellowing or leathering of	the skin; or	
	(iv) solar kertoses which have proven re-	fractory 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 operarecognised as a specialist in the specialty of de	ating theatre of a hospital by a medical practitioner ermatology or plastic surgery.	
	Applicable once only in any 12 month period	(Anaes.)	
45019	Fee: \$409.10 Benefit: 75% = \$306.85		
	ABRASIVE THERAPY for severely disfiguri to 1 aesthetic area (Anaes.)	ng scarring resulting from trauma, burns or acne - limited	
45021	(See para TN.8.91 of explanatory notes to this Cate Fee: \$182.90 Benefit: 75% = \$137.20	- •	
	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.)		
45024	(See para TN.8.91 of explanatory notes to this Cate Fee: \$411.00 Benefit: 75% = \$308.25		
	CARBON DIOXIDE LASER OR ERBIUM LASER (not including fractional laser therapy) resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.)		
45025	(See para TN.8.91 of explanatory notes to this Cate Fee: \$182.90 Benefit: 75% = \$137.20	85% = \$155.50	
45025 45026		ASER (not including fractional laser therapy) resurfacing urring resulting from trauma, burns or acne - more than 1	
TJU2U	of the face of ficer for severely distinguising sea	arms resulting from trauma, burns of ache - more than I	

T8. SUF	RGICAL OPERATION	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	aesthetic area (An	aes.)	
	Fee: \$411.00	f explanatory notes to this Category) Benefit: 75% = \$308.25 85% = \$349.35 are Safety Net Cap: \$328.80	
	ANGIOMA, caute (Anaes.)	erisation of or injection into, where undertaken in the operating theatre of a hospital	
45027	Fee: \$124.15	Benefit: 75% = \$93.15 85% = \$105.55	
		nangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial or mucous surface, small, excision and suture of (Anaes.)	
45030	Fee: \$133.25	Benefit: 75% = \$99.95 85% = \$113.30	
		mangioma or lymphangioma or both), large or involving deeper tissue including facial excision and suture of (Anaes.)	
45033	Fee: \$248.20	Benefit: 75% = \$186.15 85% = \$211.00	
	ANGIOMA (haer excision of (Anae	nangioma or lymphangioma or both), large and deep, involving muscles or nerves, s.) (Assist.)	
45035	Fee: \$724.00	Benefit: 75% = \$543.00	
	ANGIOMA (haer	nangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.)	
45036	Fee: \$1,163.30	Benefit: 75% = \$872.50	
	ARTERIOVENO (Anaes.)	US MALFORMATION (3 centimetres or less) of superficial tissue, excision of	
45039	Fee: \$248.20	Benefit: 75% = \$186.15 85% = \$211.00	
	ARTERIOVENO	US MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.)	
45042	Fee: \$318.05	Benefit: 75% = \$238.55 85% = \$270.35	
	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.)		
45045	Fee: \$318.05	Benefit: 75% = \$238.55 85% = \$270.35	
		ATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or major excision of (Anaes.) (Assist.)	
45048	Fee: \$798.75	Benefit: 75% = \$599.10	
	Contour reconstru	ction 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 T8;	of a non-biological implant that is a component of another service specified in Group	
45051	(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
	(c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)
	Fee: \$488.55 Benefit: 75% = \$366.45
	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) Fee: \$253.80 Benefit: 75% = \$190.35
	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	Fee: \$1,311.00 Benefit: 75% = \$983.25
	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	Fee: \$1,311.00 Benefit: 75% = \$983.25
	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

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(i) 20% in normally shaped breasts	; or
	(ii) 10% in tubular breasts or in bre	easts with abnormally high inframammary folds; and
	(b) photographic and/or diagnostic imag documented in the patient notes.	ing evidence demonstrating the clinical need for this service is
	Applicable only once per occasion on wh	hich the service is provided (Anaes.) (Assist.)
	Fee: \$948.70 Benefit: 75% = \$71	1.55
		SKIN FLAP SURGERY
		pair one defect, simple and small, excluding flap for male pattern e advancement flap not in association with any of items 31356 to
45200	(See para TN.8.93 of explanatory notes to the Fee: \$293.25 Benefit: 75% = \$21 Extended Medicare Safety Net Cap: \$	9.95 85% = \$249.30
	Muscle, myocutaneous or skin flap, whe removal of a malignant or non-malignan	re clinically indicated to repair one surgical excision made in the at skin lesion (only in association with items 31000, 31001, 359, 31360, 31363, 31364, 31369, 31370, 31371, 31373 or
45201	(See para TN.8.93 of explanatory notes to the Fee: \$426.85 Benefit: 75% = \$32	is Category) 0.15 85% = \$362.85
		re clinically indicated to repair one surgical excision made in the it skin lesion in a patient, if the clinical relevance of the ient'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 eith	her:
	(i) the patient has severe pre-existing	ng scarring, severe skin atrophy or sclerodermoid changes; or
	(ii) the repair is contiguous with a f	ree margin (Anaes.)
45202	(See para TN.8.93, TN.8.126 of explanatory Fee: \$426.85 Benefit: 75% = \$32	notes to this Category) 0.15 85% = \$362.85
		pair one defect, complicated or large, excluding flap for male r double advancement flap not in association with any of items
45203	(See para TN.8.93 of explanatory notes to the Fee: \$418.75 Benefit: 75% = \$31. Extended Medicare Safety Net Cap: \$	4.10 85% = \$355.95
13203	Single stage local flap if indicated to rep	pair one defect, on eyelid, nose, lip, ear, neck, hand, thumb, or double advancement flap not in association with any of items
45206	(See para TN.8.93 of explanatory notes to the Fee: \$395.55 Benefit: 75% = \$29 Extended Medicare Safety Net Cap: \$	6.70 85% = \$336.25

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGER
		ement flap if indicated to repair one defect, on eyelid, eyebrow or forehead not of items 31356 to 31376 (Anaes.)
45207	Fee: \$395.55 Be	nefit: 75% = \$296.70 85% = \$336.25
	DIRECT FLAP REPAIR	R (cross arm, abdominal or similar), first stage (Anaes.) (Assist.)
45209	Fee: \$488.55 Be	nefit: 75% = \$366.45 85% = \$415.30
	DIRECT FLAP REPAIR	R (cross arm, abdominal or similar), second stage (Anaes.)
45212	Fee: \$242.40 Be	nefit: 75% = \$181.80 85% = \$206.05
	DIRECT FLAP REPAIR	R, cross leg, first stage (Anaes.) (Assist.)
45215	Fee: \$1,045.70 Be	nefit: 75% = \$784.30
	DIRECT FLAP REPAIR	R, cross leg, second stage (Anaes.) (Assist.)
45218	Fee: \$469.10 Be	nefit: 75% = \$351.85
		R, small (cross finger or similar), first stage (Anaes.)
45221	Fee: \$269.75 Be	nefit: 75% = \$202.35 85% = \$229.30
	DIRECT FLAP REPAIR	R, small (cross finger or similar), second stage (Anaes.)
45224	Fee: \$121.25 Be	nefit: 75% = \$90.95 85% = \$103.10
	INDIRECT FLAP OR T	TUBED PEDICLE, formation of (Anaes.) (Assist.)
45227	Fee: \$459.35 Be	nefit: 75% = \$344.55 85% = \$390.45
	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (Anaes.)	
45230	Fee: \$229.70 Be	nefit: 75% = \$172.30 85% = \$195.25
	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (Anaes.) (Assist.)	
45233	Fee: \$488.55 Be	nefit: 75% = \$366.45 85% = \$415.30
	INDIRECT FLAP OR T	UBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes.)
45236	Fee: \$383.10 Be	nefit: 75% = \$287.35
	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by incision and suture, not being a service to which item 45240 applies (Anaes.)	
45239	Fee: \$269.75 Be	nefit: 75% = \$202.35 85% = \$229.30
	DIRECT, INDIRECT OR LOCAL FLAP, revision of, by liposuction, not being a service to which item 45239, 45497, 45498 or 45499 applies (Anaes.)	
45240	Fee: \$269.75 Be	nefit: 75% = \$202.35 85% = \$229.30
		FREE GRAFTS
	FREE GRAFTING (spli	t skin) of a granulating area, small (Anaes.)
45400	Fee: \$211.10 Benefit: 75% = \$158.35 85% = \$179.45	
	FREE GRAFTING (spli	t skin) of a granulating area, extensive (Anaes.) (Assist.)
45403	Fee: \$420.20 Be	nefit: 75% = \$315.15 85% = \$357.20

. SURGIO	CAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	REE GRAFTING (split skin) to burns, includer cent of total body surface (Anaes.) (Assist	ding excision of burnt tissue - involving not more than 3
	Gee para TN.8.94 of explanatory notes to this Cate ee: \$465.15 Benefit: 75% = \$348.90	
	REE GRAFTING (split skin) to burns, include the less than 6 per cent of total body surface (A)	ding excision of burnt tissue - involving 3 per cent or more Anaes.) (Assist.)
	See para TN.8.94 of explanatory notes to this Cate ee: \$620.45 Benefit: 75% = \$465.35	gory)
	REE GRAFTING (split skin) to burns, include ut less than 9 per cent of total body surface (A	ding excision of burnt tissue - involving 6 per cent or more Anaes.) (Assist.)
	See para TN.8.94 of explanatory notes to this Cate ee: \$853.15 Benefit: 75% = \$639.90	gory)
	REE GRAFTING (split skin) to burns, include ut less than 12 per cent of total body surface	ling excision of burnt tissue - involving 9 per cent or more (Anaes.) (Assist.)
	See para TN.8.94 of explanatory notes to this Cate ree: \$930.50 Benefit: 75% = \$697.90	gory)
	REE GRAFTING (split skin) to burns, include nore but less than 15 per cent of total body su	ding excision of burnt tissue - involving 12 per cent or rface (Anaes.) (Assist.)
	See para TN.8.94 of explanatory notes to this Cate ee: \$1,008.10 Benefit: 75% = \$756.10	gory)
F	REE GRAFTING (split skin) to 1 defect, inc	luding elective dissection, small (Anaes.)
4 39 F	Benefit: 75% = \$219.95	85% = \$249.30
F	REE GRAFTING (split skin) to 1 defect, inc	luding elective dissection, extensive (Anaes.) (Assist.)
442 F	Benefit: 75% = \$453.65	85% = \$520.15
	REE GRAFTING (split skin) as inlay graft to ncluding insertion of, and removal of mould?	o 1 defect including elective dissection using a mould (Anaes.) (Assist.)
445 F	Benefit: 75% = \$430.50	85% = \$489.30
		luding elective dissection on eyelid, nose, lip, ear, neck, rvice to which item 45442 or 45445 applies (Anaes.)
448 F	Benefit: 75% = \$290.85	85% = \$329.60
	REE GRAFTING (full thickness), to 1 defec Assist.)	t, excluding grafts for male pattern baldness (Anaes.)
4 51 F	Benefit: 75% = \$366.45	85% = \$415.30
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 15 percent or more but less than 20 percent of total body surface - one surgeon (Anaes.) (Assist.)	
460 F	Benefit: 75% = \$969.35	
m		ding excision of burnt tissue - involving 15 percent or rface - conjoint surgery, principal surgeon (Anaes.)
461 F	Benefit: 75% = \$690.90	
460 F <i>m</i> (<i>f</i>	REE GRAFTING (split skin) to burns, include to but less than 20 percent of total body surface: \$1,292.45 Benefit: 75% = \$969.35 REE GRAFTING (split skin) to burns, include to but less than 20 percent of total body surfaces.)	ding excision of burnt tissue - involving 15 percentage - one surgeon (Anaes.) (Assist.) ding excision of burnt tissue - involving 15 percentage

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
		cluding excision of burnt tissue - involving 15 percent or surface - conjoint surgery, co- surgeon (Assist.)
45462	Fee: \$695.10 Benefit: 75% = \$521.3	35
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - one surgeon (Anaes.) (Assist.)	
45464	Fee: \$1,972.85 Benefit: 75% = \$1479	.65
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 20 percent or more but less than 30 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	
45465	Fee: \$1,405.55 Benefit: 75% = \$1054	.20 85% = \$1320.85
		cluding excision of burnt tissue - involving 20 percent or surface - conjoint surgery, co-surgeon (Assist.)
45466	Fee: \$1,060.05 Benefit: 75% = \$795.0	05 85% = \$975.35
		cluding excision of burnt tissue - involving 30 percent or surface - conjoint surgery, principal surgeon (Anaes.)
45468	Fee: \$1,889.90 Benefit: 75% = \$1417	.45
		cluding excision of burnt tissue - involving 30 percent or surface - conjoint surgery, co-surgeon (Assist.)
45469	Fee: \$1,425.85 Benefit: 75% = \$1069	.40 85% = \$1341.15
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 40 percent or more but less than 50 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.)	
45471	Fee: \$2,375.60 Benefit: 75% = \$1781	.70 85% = \$2290.90
		cluding excision of burnt tissue - involving 40 percent or surface - conjoint surgery, co-surgeon (Assist.)
45472	Fee: \$1,791.90 Benefit: 75% = \$1343	.95 85% = \$1707.20
		cluding excision of burnt tissue - involving 50 percent or v surface - conjoint surgery, principal surgeon (Anaes.)
45474	Fee: \$2,859.90 Benefit: 75% = \$2144	.95 85% = \$2775.20
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 50 percent or more but less than 60 percent of total body surface - conjoint surgery, co-surgeon (Assist.)	
45475	Fee: \$2,157.85 Benefit: 75% = \$1618	.40 85% = \$2073.15
		cluding excision of burnt tissue - involving 60 percent or surface - conjoint surgery, principal surgeon (Anaes.)
15177	Fee: \$3,344.30 Benefit: 75% = \$2508.25 85% = \$3259.60	
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 60 percent or	

T8. SUF	Γ8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	more but less than	170 percent of total body sur	face - conjoint surgery, co-surgeon (Assist.)	
	Fee: \$2,522.50	Benefit: 75% = \$1891.90	85% = \$2437.80	
			ling excision of burnt tissue - involving 70 percent or face - conjoint surgery, principal surgeon (Anaes.)	
45480	Fee: \$3,828.60	Benefit: 75% = \$2871.45	85% = \$3743.90	
			ling excision of burnt tissue - involving 70 percent or face - conjoint surgery, co-surgeon (Assist.)	
45481	Fee: \$2,888.60	Benefit: 75% = \$2166.45	85% = \$2803.90	
			ling excision of burnt tissue - involving 80 percent or principal surgeon (Anaes.) (Assist.)	
45483	Fee: \$4,362.10	Benefit: 75% = \$3271.60	85% = \$4277.40	
		G (split skin) to burns, includy surface - conjoint surgery, o	ling excision of burnt tissue - involving 80 percent or co-surgeon (Assist.)	
45484	Fee: \$3,291.20	Benefit: 75% = \$2468.40	85% = \$3206.50	
		G (split skin) to burns, included (Anaes.) (Assist.)	ling excision of burnt tissue - upper eyelid, nose, lip, ear	
45485	Fee: \$544.20	Benefit: 75% = \$408.15		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.)			
45486	Fee: \$465.15	Benefit: 75% = \$348.90		
	FREE GRAFTIN (Assist.)	G (split skin) to burns, include	ling excision of burnt tissue - whole of toe (Anaes.)	
45487	Fee: \$418.75	Benefit: 75% = \$314.10	85% = \$355.95	
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.)		ling excision of burnt tissue - the whole of 1 digit of the	
45488	Fee: \$465.15	Benefit: 75% = \$348.90		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.)		ling excision of burnt tissue - the whole of 2 digits of the	
45489	Fee: \$697.95	Benefit: 75% = \$523.50	85% = \$613.25	
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.)		ling excision of burnt tissue - the whole of 3 digits of the	
45490	Fee: \$930.70	Benefit: 75% = \$698.05		
	FREE GRAFTING hand (Anaes.) (As		ling excision of burnt tissue - the whole of 4 digits of the	
45491	Fee: \$1,163.30	Benefit: 75% = \$872.50		
	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.)			

T8. SUF	8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$1,395.90	Benefit: 75% = \$1046.9	95	
	FREE GRAFTIN (Anaes.) (Assist.)		luding excision of burnt tissue - portion of digit of hand	
45493	Fee: \$418.75	Benefit: 75% = \$314.10		
	FREE GRAFTIN ears) (Anaes.) (A		luding excision of burnt tissue - whole of face (excluding	
45494	Fee: \$1,689.85	Benefit: 75% = \$1267.4	10 85% = \$1605.15	
		OTHER GRAFTS AN	ID MISCELLANEOUS PROCEDURES	
	FLAP, free tissue	transfer using microvascu	lar techniques - revision of, by open operation (Anaes.)	
45496	Fee: \$429.05	Benefit: 75% = \$321.80		
		transfer using microvascu a of, by liposuction (Anaes.	lar techniques, <i>or</i> any autogenous breast reconstruction -	
45497	Fee: \$335.10	Benefit: 75% = \$251.35	5	
	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast recons staged revision of, by liposuction - first stage (Anaes.)			
45498	Fee: \$269.75	Benefit: 75% = \$202.35	5	
	FLAP, free tissue transfer using microvascular techniques, <i>or</i> any autogenous breast reconstruction - <i>staged revision of</i> , by liposuction - second stage (Anaes.)			
45499	Fee: \$201.05	Benefit: 75% = \$150.80		
	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.)			
45500	Fee: \$1,124.40 Benefit: 75% = \$843.30			
		MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation limb or digit (Anaes.) (Assist.)		
45501	Fee: \$1,830.15	Benefit: 75% = \$1372.6	55	
	MICROVASCUI limb or digit (Ana		vein using microsurgical techniques, for re-implantation of	
45502	Fee: \$1,830.15	Benefit: 75% = \$1372.6	55	
	MICRO-ARTER	IAL OR MICRO-VENOU	S GRAFT using microsurgical techniques (Anaes.) (Assist.)	
45503	Fee: \$2,093.80	Benefit: 75% = \$1570.3	15	
	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.)			
45504	Fee: \$1,830.15	Benefit: 75% = \$1372.6	55	
MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, tissue including setting in of free flap (Anaes.) (Assist.)				
45505	Fee: \$1,830.15	Benefit: 75% = \$1372.65		
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating			

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	theatre of a hospital, or wher	e performed by a specialist in the practice of his or her specialty (Anaes.)
	(See para TN.8.95 of explanator Fee: \$226.80 Benefit	ry notes to this Category): 75% = \$170.10 85% = \$192.80
		than 3 cm in length, revision of, where undertaken in the operating theatre rmed by a specialist in the practice of his or her specialty (Anaes.)
45512	(See para TN.8.95 of explanator Fee: \$304.95 Benefit	ry notes to this Category): 75% = \$228.75
	· ·	neck, not more than 7 cms in length, revision of, as an independent in the operating theatre of a hospital or where performed by a specialist in cialty (Anaes.)
45515	(See para TN.8.95 of explanator Fee: \$192.35 Benefit	ry notes to this Category) :: 75% = \$144.30
		neck, more than 7 cms in length, revision of, as an independent procedure, rating theatre of a hospital, or where performed by a specialist in the ty (Anaes.)
45518	(See para TN.8.95 of explanator Fee: \$232.75 Benefit	ry notes to this Category) 2: 75% = \$174.60 85% = \$197.85
	EXTENSIVE BURN SCAR correction of scar contracture	S OF SKIN (more than 1 percent of body surface area), excision of, for e (Anaes.) (Assist.)
45519	Fee: \$442.45 Benefit	: 75% = \$331.85
		ilateral) with surgical repositioning of nipple, in the context of breast cancer by of the breast (Anaes.) (Assist.)
45520	Fee: \$928.55 Benefit	: 75% = \$696.45
	Reduction mammaplasty (un	ilateral) without surgical repositioning of the nipple:
	(a) excluding the treatment of	f gynaecomastia; and
	(b) not with insertion of any	prosthesis (Anaes.) (Assist.)
45522	Fee: \$651.50 Benefit	: 75% = \$488.65
		lateral) with surgical repositioning of the nipple:
	(a) for patients with macrom	astia and experiencing pain in the neck or shoulder region; and
	(b) not with insertion of any	prosthesis (Anaes.) (Assist.)
45523	Fee: \$1,392.90 Benefit	: 75% = \$1044.70
		n (unilateral) in the context of:
	(a) breast cancer; or	
(b) developmental abnormality of the breast, if there is a difference in breast volume, an appropriate volumetric measurement technique, of at least:		· ·
45524	(i) 20% in normally sha	aped breasts; or

T8. SUR	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(ii) 10% in tubular	breasts or in breasts with abnormally high inframammary folds.
	Applicable only once pe	er occasion on which the service is provided (Anaes.) (Assist.)
	-	anatory notes to this Category) nefit: 75% = \$573.60
	Breast reconstruction (u	nilateral), following mastectomy, using a permanent prosthesis (Anaes.) (Assist.)
45527	-	anatory notes to this Category) enefit: 75% = \$573.60
	Mammaplasty, augment	tation, bilateral (other than a service to which item 45527 applies), if:
	(a) reconstructive surger	ry is indicated because of:
	(i) developmental	malformation of breast tissue (excluding hypomastia); or
	(ii) disease of or tr surgery); or	rauma to the breast (other than trauma resulting from previous elective cosmetic
	(iii) amastia secon	dary to a congenital endocrine disorder; and
		diagnostic imaging evidence demonstrating the clinical need for this service is nt notes (Anaes.) (Assist.)
45528		anatory notes to this Category) enefit: 75% = \$860.35
	including repair of secon	inilateral), using a latissimus dorsi or other large muscle or myocutaneous flap, indary skin defect, if required, excluding repair of muscular aponeurotic layer, ociated with a service to which item 30165, 30168, 30171, 30172, 30176, 30177
	(H) (Anaes.) (Assist.)	
(See para TN.8.97 of explanatory notes to this Category) 45530		
		UCTION using breast sharing technique (first stage) including breast reduction, a and breast tissue flap, split skin graft to pedicle of flap or other similar sist.)
45533		natory notes to this Category) enefit: 75% = \$963.00
	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.	
45536	Fee: \$472.20 Be	enefit: 75% = \$354.15
		UCTION (unilateral), following mastectomy, using tissue expansion - insertion and all attendances for subsequent expansion injections (Anaes.) (Assist.)
45539	Fee: \$1,104.70 Be	enefit: 75% = \$828.55
		UCTION (unilateral), following mastectomy, using tissue expansion - removal of d insertion of permanent prosthesis (Anaes.) (Assist.)
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T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.)	
45545	(See para TN.8.100 of explanatory notes to this Category) Fee: \$642.00 Benefit: 75% = \$481.50 85% = \$557.30 Extended Medicare Safety Net Cap: \$513.60	
	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple	
45546	(See para TN.8.100 of explanatory notes to this Category) Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40	
	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.)	
45548	Fee: \$285.45 Benefit: 75% = \$214.10 85% = \$242.65	
	Breast prosthesis, removal of, with excision of at least half of the fibrous capsule, not with insertion of any prosthesis. The excised specimen must be sent for histopathology and the volume removed must be documented in the histopathology report (Anaes.) (Assist.)	
45551	Fee: \$457.55 Benefit: 75% = \$343.20	
	Breast prosthesis, removal of and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), if:	
	(a) either:	
	(i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or	
	(ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and	
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	
45553	(See para TN.8.98 of explanatory notes to this Category) Fee: \$589.45 Benefit: 75% = \$442.10	
	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (for rupture, migration of prosthetic material or symptomatic capsular contracture), including excision of at least half of the fibrous capsule or formation of a new pocket, or both, if:	
	(a) either:	
	(i) it is demonstrated by intra-operative photographs post-removal that removal alone would cause unacceptable deformity; or	
	(ii) the original implant was inserted in the context of breast cancer or developmental abnormality; and	
	(b) the excised specimen is sent for histopathology and the volume removed is documented in the histopathology report; and	
	(c) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)	
45554	(See para TN.8.98 of explanatory notes to this Category) Fee: \$721.30 Benefit: 75% = \$541.00	

T8. SUR	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	photographic evidence (including ant	l), in the context of breast cancer or developmental abnormality, if erior, left lateral and right lateral views) and/or diagnostic imaging eed for this service is documented in the patient notes
	Applicable only once per occasion on	which the service is provided (Anaes.) (Assist.)
45556	(See para TN.8.99 of explanatory notes to Fee: \$789.95 Benefit: 75% = \$	± •
	Breast ptosis, correction by mastopex	y of (bilateral), if:
		sue, including the nipple, lies inferior to the infra-mammary fold at dependent, inferior part of the breast contour; and
	(b) if the patient has been pregnant—years, after completion of the most re	the correction is performed not less than 1 year, or more than 7 cent pregnancy of the patient; and
		anterior, left lateral and right lateral views), with a marker at the onstrating the clinical need for this service, is documented in the
	Applicable only once per lifetime (An	naes.) (Assist.)
45558	(See para TN.8.99 of explanatory notes to Fee: \$1,184.85 Benefit: 75% = \$	
		e treatment of alopecia of congenital or traumatic origin or due to less, not being a service to which another item in this Group applies
45560	Fee: \$488.45 Benefit: 75% = \$ Extended Medicare Safety Net Cap	\$366.35 85% = \$415.20 •• \$171.00
	MICROVASCULAR ANASTOMOS supercharging of pedicled flaps (Anac	SIS of artery or vein using microsurgical techniques, for es.) (Assist.)
45561	Fee: \$1,830.15 Benefit: 75% = \$	\$1372.65
		lving raising of tissue on vascular or neurovascular pedicle, utaneous defect if performed, excluding flap for male pattern
45562	Fee: \$1,133.75 Benefit: 75% = 5	\$850.35 85% = \$1049.05
	NEUROVASCULAR ISLAND FLA performed, excluding flap for male particularly performed and performed	P, including direct repair of secondary cutaneous defect if attern baldness (Anaes.) (Assist.)
45563	Fee: \$1,133.75 Benefit: 75% = 5	\$850.35 85% = \$1049.05
	deformity, surgery or trauma, involvi and including raising of tissue on a va- transfer of tissue, insetting of tissue a performed, other than a service assoc	surgery for the repair of major tissue defect due to congenital ng anastomoses of up to 2 vessels using microvascular techniques ascular or neurovascular pedicle, preparation of recipient vessels, t recipient site and direct repair of secondary cutaneous defect if iated with a service to which item 30165, 30168, 30171, 30172, 45504, 45505 or 45562 applies-conjoint surgery, principal st.)
45564	(See para TN.8.8 of explanatory notes to Fee: \$2,625.85 Benefit: 75% = \$	

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	deformity, surgery or trauma, i and including raising of tissue transfer of tissue, insetting of t performed, other than a service	uctive surgery for the repair of major tissue defect due to congenital involving anastomoses of up to 2 vessels using microvascular techniques on a vascular or neurovascular pedicle, preparation of recipient vessels, issue at recipient site and direct repair of secondary cutaneous defect if a associated with a service to which item 30165, 30168, 30171, 30172, 45502, 45504, 45505 or 45562 applies-conjoint surgery, conjoint specialist
45565	(See para TN.8.8 of explanatory n Fee: \$1,969.45 Benefit:	notes to this Category) $75\% = \$1477.10$
		ing a service to which item 45539 or 45542 applies - insertion of tissue nees for subsequent expansion injections (Anaes.) (Assist.)
45566	Fee: \$1,104.70 Benefit:	75% = \$828.55
	TISSUE EXPANDER, remova	al of, with complete excision of fibrous capsule (Anaes.) (Assist.)
45568	Fee: \$457.55 Benefit:	75% = \$343.20
		VITH RECONSTRUCTION OF UMBILICUS, with or without lipectomy, a items 45562, 45564, 45565 or 45530 (Anaes.) (Assist.)
45569	Fee: \$698.80 Benefit:	75% = \$524.10
	CLOSURE OF ABDOMEN, repair of musculoaponeurotic layer, being a service associated with item 45569 (Anaes.) (Assist.)	
45570	Fee: \$943.55 Benefit:	75% = \$707.70 85% = \$858.85
	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.)	
45572	Fee: \$300.80 Benefit:	75% = \$225.60 85% = \$255.70
	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.)	
45575	Fee: \$742.70 Benefit:	75% = \$557.05 85% = \$658.00
	FACIAL NERVE PARALYSI	(S, muscle transfer for (Anaes.) (Assist.)
45578	Fee: \$860.10 Benefit:	75% = \$645.10
	FACIAL NERVE PALSY, exc	cision of tissue for (Anaes.)
45581	Fee: \$285.45 Benefit:	75% = \$214.10 85% = \$242.65
	Liposuction (suction assisted lipolysis) to one regional area (one limb or trunk), for treatment of post traumatic pseudolipoma, if photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.)	
45584	(See para TN.8.8, TN.8.101 of ex Fee: \$651.50 Benefit:	planatory notes to this Category) 75% = \$488.65
	Liposuction (suction assisted l associated with a service to wh	ipolysis) to one regional area (one limb or trunk), other than a service nich item 31525 applies, if:
	(a) the liposuction is for:	
45585		quer-Simons syndrome, lymphoedema or macrodystrophia lipomatosa; or

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(ii) the reduction of a buffalo hum treatment of a medical condition;	p that is secondary to an endocrine disorder or pharmacological and
	(b) photographic and/or diagnostic imag documented in the patient notes (Anaes	ging evidence demonstrating the clinical need for this service is
	(See para TN.8.8, TN.8.101 of explanatory of Fee: \$651.50 Benefit: 75% = \$48	
	Meloplasty for correction of facial asyn	nmetry if:
	(a) the asymmetry is secondary to traum medical condition (such as facial nerve	na (including previous surgery), a congenital condition or a palsy); and
	(b) the meloplasty is limited to one side	of the face (Anaes.) (Assist.)
45587	(See para TN.8.102 of explanatory notes to Fee: \$918.70 Benefit: 75% = \$68	
	Meloplasty (excluding browlifts and chi	inlift platysmaplasties), bilateral, if:
		tional impairment due to a congenital condition, disease a (other than trauma resulting from previous elective cosmetic
	(b) photographic and/or diagnostic imag documented in the patient notes (Anaes	ging evidence demonstrating the clinical need for this service is a) (Assist.)
45588	(See para TN.8.102 of explanatory notes to Fee: \$1,378.15 Benefit: 75% = \$10	
	ORBITAL CAVITY, reconstruction of	a wall or floor, with or without foreign implant (Anaes.) (Assist.)
45590	Fee: \$498.35 Benefit: 75% = \$3	73.80
	ORBITAL CAVITY, bone or cartilage entrapped orbital contents (Anaes.) (Ass	graft to orbital wall or floor including reduction of prolapsed or sist.)
45593	Fee: \$585.40 Benefit: 75% = \$43	39.05
	MAXILLA, total resection of (Anaes.)	(Assist.)
45596	Fee: \$928.55 Benefit: 75% = \$69	96.45
	MAXILLA, total resection of both max	illae (Anaes.) (Assist.)
45597	Fee: \$1,243.05 Benefit: 75% = \$93	32.30
	MANDIBLE, total resection of both sid	es, including condylectomies where performed (Anaes.) (Assist.)
45599	Fee: \$965.80 Benefit: 75% = \$72	24.35 85% = \$881.10
	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.)	
45602	Fee: \$721.30 Benefit: 75% = \$54	41.00
	MANDIBLE OR MAXILLA, segmenta	l resection of, for tumours or cysts (Anaes.) (Assist.)
45605	Fee: \$605.95 Benefit: 75% = \$454.50	
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a	

T8. SUF	T8. SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	service to which item 455	599 applies (Anaes.)	(Assist.)	
	Fee: \$853.15 Ben	nefit: 75% = \$639.90		
	MANDIBLE, condylecto		.)	
45611	Fee: \$488.55 Ben	nefit: 75% = \$366.45		
43011			RUCTION OF other than by direct suture only (Anaes.)	
45614	Fee: \$605.95 Ben Extended Medicare Saf	nefit: 75% = \$454.50 lety Net Cap: \$484.8		
	Upper eyelid, reduction of	of, if:		
	(a) the reduction is for an	y of the following:		
			field defect (confirmed by an optometrist or mmation of the eyelid;	
	(ii) herniation of or	bital fat in exophthal	lmos;	
	(iii) facial nerve pal	(iii) facial nerve palsy;		
	(iv) post-traumatic scarring;			
		r) the restoration of symmetry of contralateral upper eyelid in respect of one of the conditions entioned in subparagraphs (i) to (iv); and		
	(b) photographic and/or of documented in the patien		vidence demonstrating the clinical need for this service is	
45617	(See para TN.8.103 of explain Fee: \$242.40 Ben Extended Medicare Saf	nefit: 75% = \$181.80	85% = \$206.05	
	Lower eyelid, reduction of	of, if:		
	(a) the reduction is for:			
	(i) herniation of orb	oital fat in exophthal	mos, facial nerve palsy or post-traumatic scarring; or	
	(ii) the restoration of symmetry of the contralateral lower eyelid in respect of one of these conditions; and			
	(b) photographic and/or diagnostic imaging evidence demonstrating the clinical need for this service documented in the patient notes (Anaes.)			
45620	(See para TN.8.103 of explain Fee: \$336.20 Ben Extended Medicare Saf	nefit: 75% = \$252.15	85% = \$285.80	
	Ptosis of upper eyelid (ur	nilateral), correction	of, by:	
45623	(a) sutured elevation of the aponeurosis); or	ne tarsal plate on the	eyelid retractors (Muller's or levator muscle or levator	
15025				

T8. SUR	RGICAL OPERATIONS 13.	PLASTIC AND RECONSTRUCTIVE SURGERY
	(b) sutured suspension to the brow/frontalis muscle	;
	Not applicable to a service for repair of mechanical	ptosis to which item 45617 applies (Anaes.) (Assist.)
	Fee: \$745.60 Benefit: 75% = \$559.20 85% = \$660.90 Extended Medicare Safety Net Cap: \$596.50	
	Ptosis of upper eyelid, correction of, by:	
	(a) sutured elevation of the tarsal plate on the eyelic aponeurosis); or	l retractors (Muller's or levator muscle or levator
	(b) sutured suspension to the brow/frontalis muscle	;
	if a previous ptosis surgery has been performed on	that side (Anaes.) (Assist.)
	Fee: \$966.70 Benefit: 75% = \$725.05 85%	= \$882.00
45624	Extended Medicare Safety Net Cap: \$773.40	
	PTOSIS of eyelid, correction of eyelid height by re repair by levator resection or advancement, perforn	vision of levator sutures within one week of primary ned in the operating theatre of a hospital (Anaes.)
45625	Fee: \$193.40 Benefit: 75% = \$145.05	
	Ectropion or entropion, not caused by trachoma, co	rrection of (unilateral) (Anaes.)
45626	Fee: \$336.20 Benefit: 75% = \$252.15 85%	= \$285.80
	Ectropion or entropion, caused by trachoma, correct	tion of (unilateral) (Anaes.)
45627 S	Fee: \$336.20 Benefit: 75% = \$252.15 85%	= \$285.80
	SYMBLEPHARON, grafting for (Anaes.) (Assist.)	
45629	Fee: \$488.55 Benefit: 75% = \$366.45 85%	= \$415.30
	Rhinoplasty, partial, involving correction of lateral	or alar cartilages, if:
	(a) the indication for surgery is:	
	(i) airway obstruction and the patient has a se	If-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congenital or develop	omental deformity; and
	(b) photographic and/or NOSE Scale evidence demonstrating the clinical need for this servidocumented in the patient notes (Anaes.)	
45.00	(See para TN.8.104 of explanatory notes to this Category Fee: \$527.95 Benefit: 75% = \$396.00 85%	
45632	Extended Medicare Safety Net Cap: \$422.40 Rhinoplasty, partial, involving correction of bony v	roult only, if
		auit omy, 11.
	(a) the indication for surgery is:	
	(i) airway obstruction and the patient has a se	If-reported NOSE Scale score of greater than 45; or
	(ii) significant acquired, congenital or develop	pmental deformity; and
45635	(b) photographic and/or NOSE Scale evidence dem	onstrating the clinical need for this service is

GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
documented in the patient notes (Anae	es.)	
(See para TN.8.104 of explanatory notes to Fee: \$605.95 Benefit: 75% = \$ Extended Medicare Safety Net Cap:	454.50 85% = \$521.25	
Rhinoplasty, total, including correction or without autogenous cartilage or bon	n of all bony and cartilaginous elements of the external nose, with ne graft from a local site (nasal), if:	
(a) the indication for surgery is:		
(i) airway obstruction and the pa	tient has a self-reported NOSE Scale score of greater than 45; or	
(ii) significant acquired, congeni	tal or developmental deformity; and	
(b) photographic and/or NOSE Scale edocumented in the patient notes (Anae	evidence demonstrating the clinical need for this service is es.)	
(See para TN.8.104 of explanatory notes to Fee: \$1,099.30 Benefit: 75% = \$1		
	n of all bony and cartilaginous elements of the external nose e graft obtained from distant donor site, including obtaining of	
(a) the indication for surgery is:		
(i) airway obstruction and the pa	tient 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.) (Assist.)		
(See para TN.8.104 of explanatory notes to Fee: \$1,319.40 Benefit: 75% = \$9		
CHOANAL ATRESIA, repair of by p	uncture and dilatation (Anaes.)	
Fee: \$230.60 Benefit: 75% = \$	172.95	
CHOANAL ATRESIA - correction by	y open operation with bone removal (Anaes.) (Assist.)	
Fee: \$928.55 Benefit: 75% = \$6	696.45 85% = \$843.85	
FACE, contour restoration of 1 region which item 45644 applies) (Anaes.) (A	, using autogenous bone or cartilage graft (not being a service to Assist.)	
(See para TN.8.105 of explanatory notes to Fee: \$1,319.40 Benefit: 75% = \$0		
Rhinoplasty, revision of, 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 of	evidence demonstrating the clinical need for this service is	
	(See para TN.8.104 of explanatory notes to Fee: \$605.95 Benefit: 75% = \$ Extended Medicare Safety Net Cap: Rhinoplasty, total, including correctio or without autogenous cartilage or bor (a) the indication for surgery is: (i) airway obstruction and the particle (ii) significant acquired, congenit (b) photographic and/or NOSE Scale of documented in the patient notes (Anactive See para TN.8.104 of explanatory notes to Fee: \$1,099.30 Benefit: 75% = \$ Rhinoplasty, total, including correction involving autogenous bone or cartilage graft, if: (a) the indication for surgery is: (i) airway obstruction and the particle (ii) significant acquired, congenit (b) photographic and/or NOSE Scale of documented in the patient notes (Anactive See para TN.8.104 of explanatory notes to Fee: \$1,319.40 Benefit: 75% = \$ CHOANAL ATRESIA, repair of by particle (See para TN.8.105 of explanatory notes to Fee: \$928.55 Benefit: 75% = \$ FACE, contour restoration of 1 region which item 45644 applies) (Anaes.) (Anacs.) (Anacs.	

GICAL OPERAT	ONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY	
documented in th	e patient notes (Anaes.)	
(See para TN.8.10 Fee: \$152.40	# of explanatory notes to this Category) Benefit: 75% = \$114.30 85% = \$129.55	
Rhinophyma of a (Anaes.)	moderate or severe degree, carbon dioxide laser or erbium laser excision - ablation of	
Fee: \$367.50 Extended Medic	Benefit: 75% = \$275.65 85% = \$312.40 eare Safety Net Cap: \$294.00	
RHINOPHYMA	, shaving of (Anaes.)	
Fee: \$367.50	Benefit: 75% = \$275.65 85% = \$312.40	
COMPOSITE G	RAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.)	
Fee: \$517.95	Benefit: 75% = \$388.50 85% = \$440.30	
	ongenital deformity of the ear if:	
(a) the congenit	al deformity is not related to a prominent ear; and	
(b) the deformity has been clinically diagnosed as a constricted ear, Stahl's ear, or a similar congenital deformity; and		
	c evidence demonstrating the clinical need for this service is documented in the patient Assist.)	
Fee: \$537.55	Benefit: 75% = \$403.20	
Correction of a c	ongenital deformity of the ear if:	
(a) the patient is less than 18 years of age; and		
(b) the deformity is characterised by an absence of the antihelical fold and/or large scapha and/or large concha; and		
(c) photographic evidence demonstrating the clinical need for this service is documented in the patient notes (Anaes.) (Assist.)		
Fee: \$537.55	Benefit: 75% = \$403.20	
grafts to form a f	R, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage ramework, including the harvesting and sculpturing of the cartilage and its insertion, for ce, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - pecialist in the practice of his or her specialty (Anaes.) (Assist.)	
Fee: \$2,968.65	Benefit: 75% = \$2226.50	
framework using flaps and full this	R, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage cartilage previously stored in abdominal wall, including the use of local skin and fascia kness skin graft to cover cartilage (second stage) - performed by a specialist in the her specialty (Anaes.) (Assist.)	
Fee: \$1,319.40	Benefit: 75% = \$989.55	
CONGENITAL	ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.)	
	documented in the (See para TN.8.104 Fee: \$152.40 Rhinophyma of a (Anaes.) Fee: \$367.50 Extended Medic RHINOPHYMA Fee: \$367.50 COMPOSITE GI Fee: \$517.95 Correction of a control of a cont	

T8. SUF	RGICAL OPERAT	IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	LIP, EYELID O (Anaes.)	R EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures
45665	Fee: \$336.20	Benefit: 75% = \$252.15 85% = \$285.80
	VERMILIONEO	CTOMY, by surgical excision (Anaes.)
45668	Fee: \$336.20	Benefit: 75% = \$252.15 85% = \$285.80
	Vermilionectom excision - ablation	y for biopsy-confirmed cellular atypia, using carbon dioxide laser or erbium laser on (Anaes.)
45669	(See para TN.8.10 Fee: \$336.20	6 of explanatory notes to this Category) Benefit: 75% = \$252.15
	LIP OR EYELII (Assist.)	O RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.)
45671	Fee: \$860.10	Benefit: 75% = \$645.10 85% = \$775.40
	LIP OR EYELII (Anaes.)	O RECONSTRUCTION using full thickness flap (Abbe or similar), second stage
45674	Fee: \$250.15	Benefit: 75% = \$187.65 85% = \$212.65
	MACROCHEIL	IA or macroglossia, operation for (Anaes.) (Assist.)
45675	Fee: \$498.35	Benefit: 75% = \$373.80
	MACROSTOM	IA, operation for (Anaes.) (Assist.)
45676	Fee: \$593.25	Benefit: 75% = \$444.95
	CLEFT LIP, uni	lateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)
45677	Fee: \$558.25	Benefit: 75% = \$418.70
	CLEFT LIP, uni	lateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
45680	Fee: \$697.95	Benefit: 75% = \$523.50
	CLEFT LIP, bila	nteral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.)
45683	Fee: \$775.35	Benefit: 75% = \$581.55
		ateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.)
45686	Fee: \$915.25	Benefit: 75% = \$686.45
	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.)	
45689	Fee: \$269.95	Benefit: 75% = \$202.50
	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.)	
45692	Fee: \$310.15	Benefit: 75% = \$232.65 85% = \$263.65
	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.)	
45695	Fee: \$504.00	Benefit: 75% = \$378.00
45698	CLEFT LIP, pri	mary columella lengthening procedure, bilateral (Anaes.)

T8. SUF	RGICAL OPERAT	IONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	Fee: \$473.10	Benefit: 75% = \$354.85
	CLEFT LIP REC (Assist.)	CONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.)
45701	Fee: \$853.15	Benefit: 75% = \$639.90
	CLEFT LIP REC	CONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.)
45704	Fee: \$310.15	Benefit: 75% = \$232.65 85% = \$263.65
	CLEFT PALAT	E, primary repair (Anaes.) (Assist.)
45707	Fee: \$806.35	Benefit: 75% = \$604.80
	CLEFT PALAT	E, secondary repair, closure of fistula using local flaps (Anaes.)
45710	Fee: \$504.00	Benefit: 75% = \$378.00
	· ·	E, secondary repair, lengthening procedure (Anaes.) (Assist.)
45713	Fee: \$574.00	Benefit: 75% = \$430.50
13713	· ·	ISTULA, plastic closure of, including services to which item 45200, 45203 or 45239
45714	Fee: \$806.35	Benefit: 75% = \$604.80
	VELO-PHARY	NGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.)
45716	Fee: \$806.35	Benefit: 75% = \$604.80
		MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves one grafts taken from the same site and excluding services to which item 47933or aes.) (Assist.)
45720	(See para TN.8.10 Fee: \$997.00	7 of explanatory notes to this Category) Benefit: 75% = \$747.75 85% = \$912.30
	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerve 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 (Anac (Assist.)	
45723	(See para TN.8.10) Fee: \$1,124.40	7 of explanatory notes to this Category) Benefit: 75% = \$843.30
	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerve and vessels and bone grafts taken from the same site, and excluding services to which item 47933 or 47936 apply (Anaes.) (Assist.)	
(See para TN.8.107 of explanatory notes to t 45726 Fee: \$1,270.55 Benefit: 75% = \$95		7 of explanatory notes to this Category) Benefit: 75% = \$952.95
	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, s plates or pins, or any combination, and excluding services to which item 47933 or 47936 apply (Assist.)	
45729	(See para TN.8.10) Fee: \$1,426.90	7 of explanatory notes to this Category) Benefit: 75% = \$1070.20
45731	MANDIBLE or	MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
		ves and vessels and bone grafts taken from the same site, and 933 or 47936 apply (Anaes.) (Assist.)
	(See para TN.8.107 of explanatory notes Fee: \$1,446.55 Benefit: 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 screws, plates or pins, or any combination, and excluding services to (naes.) (Assist.)
45732	(See para TN.8.107 of explanatory notes Fee: \$1,628.50 Benefit: 75% =	
	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 933 or 47936 apply (Anaes.) (Assist.)
45735	(See para TN.8.107 of explanatory notes Fee: \$1,661.40 Benefit: 75% =	
	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 screws, plates or pins, or any combination, and excluding services to anaes.) (Assist.)
45738	(See para TN.8.107 of explanatory notes Fee: \$1,869.00 Benefit: 75% =	
	such procedures of 1 jaw and 2 such	plex bilateral osteotomies or osteectomies of, involving 3 or more procedures of the other jaw, including genioplasty when performed els and bone grafts taken from the same site, and excluding services (Anaes.) (Assist.)
45741	(See para TN.8.107 of explanatory notes Fee: \$1,827.65 Benefit: 75% =	
	such procedures of 1 jaw and 2 such and transposition of nerves and vesses	plex bilateral osteotomies or osteectomies of, involving 3 or more procedures of the other jaw, including genioplasty when performed els and bone grafts taken from the same site and stabilisation with ins, or any combination, and excluding services to which item ist.)
45744	(See para TN.8.107 of explanatory notes Fee: \$2,054.95 Benefit: 75% =	
	such procedures of each jaw, includi-	uplex bilateral osteotomies or osteectomies of, involving 3 or more ng genioplasty (when performed) and transposition of nerves and ne same site, and excluding services to which item 47933 or 47936
45747	(See para TN.8.107 of explanatory notes Fee: \$1,993.95 Benefit: 75% =	to this Category) \$1495.50 85% = \$1909.25
	such procedures of each jaw, includivessels and bone grafts taken from the	plex bilateral osteotomies or osteectomies of, involving 3 or more ng genioplasty when performed and transposition of nerves and ne same site and stabilisation with fixation by wires, screws, plates luding services to which item 47933 or 47936 apply (Anaes.)
45752	<u> </u>	

T8. SUF	RGICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
	(See para TN.8.107 of explanator Fee: \$2,233.40 Benefit	ry notes to this Category) 2. 75% = \$1675.05
	III(Malar-Maxillary), Le For	ES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III involving 3 or more osteotomies of the midface including transposition ne grafts taken from the same site (Anaes.) (Assist.)
45753	Fee: \$2,246.65 Benefit	: 75% = \$1685.00 85% = \$2161.95
	(Malar-Maxillary), Le Fort II nerves and vessels and bone	ES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III I involving 3 or more osteotomies of the midface including transposition of grafts taken from the same site and stabilisation with fixation by wires, combination (Anaes.) (Assist.)
45754	Fee: \$2,693.20 Benefit	: 75% = \$2019.90
	TEMPOROMANDIBULAR	PARTIAL OR TOTAL MENISCECTOMY (Anaes.) (Assist.)
45755	Fee: \$379.25 Benefit	: 75% = \$284.45 85% = \$322.40
	TEMPORO-MANDIBULAR	Q JOINT, arthroplasty (Anaes.) (Assist.)
45758	Fee: \$678.65 Benefit	: 75% = \$509.00
	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same (Anaes.) (Assist.)	
45761	(See para TN.8.108 of explanator Fee: \$772.05 Benefit	ory notes to this Category) : 75% = \$579.05
	HYPERTELORISM, correct	ion of, intracranial (Anaes.) (Assist.)
45767	Fee: \$2,590.15 Benefit	: 75% = \$1942.65 85% = \$2505.45
	HYPERTELORISM, correct	ion of, subcranial (Anaes.) (Assist.)
45770	Fee: \$1,984.00 Benefit	: 75% = \$1488.00
	TREACHER COLLINS SYN grafts (Anaes.) (Assist.)	NDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone
45773	Fee: \$1,808.15 Benefit	: 75% = \$1356.15 85% = \$1723.45
	ORBITAL DYSTOPIA (UN intracranial (Anaes.) (Assist.)	ILATERAL), CORRECTION OF, with total repositioning of 1 orbit,
45776	Fee: \$1,808.15 Benefit	: 75% = \$1356.15
	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.)	
45779	Fee: \$1,329.45 Benefit	: 75% = \$997.10
	FRONTOORBITAL ADVA	NCEMENT, UNILATERAL (Anaes.) (Assist.)
45782	Fee: \$1,016.45 Benefit	: 75% = \$762.35 85% = \$931.75
		STRUCTION for oxycephaly, brachycephaly, turricephaly or similar bital advancement) (Anaes.) (Assist.)
45785	Fee: \$1,720.20 Benefit	: 75% = \$1290.15
45788	GLENOID FOSSA, ZYGOM	MATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF,

T8. SUF	GICAL OPERATIONS	13. PLASTIC AND RECONSTRUCTIVE SURGERY
_	(Obwegeser technique) (Anaes.) (Ass	ist.)
	Fee: \$1,700.65 Benefit: 75% = \$	1275.50
	ABSENT CONDYLE AND ASCENT not including harvesting of graft mate	DING RAMUS in hemifacial microsomia, CONSTRUCTION OF, rial (Anaes.) (Assist.)
45791	Fee: \$918.70 Benefit: 75% = \$	689.05
	OSSEO-INTEGRATION PROCEDU implantable bone conduction hearing	RE - extra-oral, implantation of titanium fixture, not for system device (Anaes.)
45794	Fee: \$519.60 Benefit: 75% = \$	389.70 85% = \$441.70
	OSSEO-INTEGRATION PROCEDU conduction hearing system device (An	RE, fixation of transcutaneous abutment, not for implantable bone naes.)
45797	Fee: \$192.35 Benefit: 75% = \$	144.30 85% = \$163.50
	ORAL	AND MAXILLOFACIAL SURGERY
		E JAW CYSTS as an independent procedure to obtain material for ervice associated with an operative procedure on the same day
45799	Fee: \$30.35 Benefit: 75% = \$	22.80 85% = \$25.80
45801	subcutaneous tissue or from mucous r not being a service to which item 458 (See para TN.8.109 of explanatory notes t	
	an operation), in the oral and maxillof subcutaneous tissue or from mucous r	CARS, (other than a scar removed during the surgical approach at acial region, up to 3 cm in diameter, removal from cutaneous or membrane, where the removal is by surgical excision and suture, are than 3 but not more than 10 lesions (Anaes.) (Assist.)
45803		252.15 85% = \$285.80
		R, (other than a scar removed during the surgical approach at an al region, more than 3 cm in diameter, removal from cutaneous or nembrane (Anaes.)
45805	(See para TN.8.109 of explanatory notes t Fee: \$177.90 Benefit: 75% = \$	o this Category) 133.45 85% = \$151.25
	established by radiological examination lining and tooth structure or where a tulcer or SCAR (other than a scar	associated with a tooth or tooth fragment unless it has been on that there is a minimum of 5mm separation between the cyst umour 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, tissue (Anaes.)
45807	(See para TN.8.109 of explanatory notes t Fee: \$254.20 Benefit: 75% = \$	o this Category) 190.65 85% = \$216.10
45809		an a cyst associated with a tooth or tooth fragment unless it has ination that there is a minimum of 5mm separation between the

T8. SUF	RGICAL OPERATIO	NS 13. PLASTIC AND RECONSTRUCTIVE SURGERY
	the oral and maxillo	n structure or where a tumour or cyst has been proven by positive histopathology), in sfacial region, removal of, requiring wide excision, not being a service to which Subgroup applies (Anaes.) (Assist.)
	(See para TN.8.109 o Fee: \$383.10	f explanatory notes to this Category) Benefit: 75% = \$287.35 85% = \$325.65
		ral and maxillofacial region, removal of, from soft tissue (including muscle, fascia ne), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.)
45811	(See para TN.8.109 o. Fee: \$517.95	f explanatory notes to this Category) Benefit: 75% = \$388.50 85% = \$440.30
		ral and maxillofacial region, removal of, from soft tissue (including muscle, fascia ne), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.)
45813	(See para TN.8.109 o. Fee: \$605.95	f explanatory notes to this Category) Benefit: 75% = \$454.50 85% = \$521.25
		MANDIBLE OR MAXILLA (other than alveolar margins) for chronic osteomyelitis ination with adjoining bones (Anaes.) (Assist.)
45815	Fee: \$367.50	Benefit: 75% = \$275.65 85% = \$312.40
	OPERATION on S	KULL for OSTEOMYELITIS (Anaes.) (Assist.)
45817	Fee: \$479.05	Benefit: 75% = \$359.30 85% = \$407.20
		ANY COMBINATION OF ADJOINING BONES IN THE ORAL AND L. REGION, being bones referred to in item 45817 (Anaes.) (Assist.)
45819	Fee: \$605.90	Benefit: 75% = \$454.45 85% = \$521.20
	BONE GROWTH (Anaes.) (Assist.)	STIMULATOR IN THE ORAL AND MAXILLOFACIAL REGION, insertion of
45821	Fee: \$392.70	Benefit: 75% = \$294.55 85% = \$333.80
		more, which were inserted for dental fixation purposes to the maxilla or mandible, ag general anaesthesia where undertaken in the operating theatre of a hospital
45823	Fee: \$112.30	Benefit: 75% = \$84.25
	MANDIBULAR O	R PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.)
45825	Fee: \$348.90	Benefit: 75% = \$261.70 85% = \$296.60
	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.)	
45827	Fee: \$333.50	Benefit: 75% = \$250.15 85% = \$283.50
		BEROSITY, reduction of (Anaes.)
45829	Fee: \$254.40	Benefit: 75% = \$190.80 85% = \$216.25
	PAPILLARY HYP	ERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.)
45831	Fee: \$333.50	Benefit: 75% = \$250.15 85% = \$283.50
	·	ERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.)
45833	Fee: \$418.75	Benefit: 75% = \$314.10 85% = \$355.95

T8. SUF	RGICAL OPERATIONS 13. PLASTIC AND RECONSTRUCTIVE SURGERY		
	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.)		
45835	Fee: \$519.60 Benefit: 75% = \$389.70 85% = \$441.70		
	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.)		
45837	Fee: \$604.85 Benefit: 75% = \$453.65 85% = \$520.15		
	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.)		
45839	Fee: \$604.85 Benefit: 75% = \$453.65 85% = \$520.15		
	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.)		
45841	Fee: \$488.45 Benefit: 75% = \$366.35 85% = \$415.20		
	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.)		
45843	Fee: \$299.60 Benefit: 75% = \$224.70 85% = \$254.70		
	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)		
45845	Fee: \$519.60 Benefit: 75% = \$389.70 85% = \$441.70		
	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.)		
45847	Fee: \$192.35 Benefit: 75% = \$144.30 85% = \$163.50		
	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.)		
45849	Fee: \$599.05 Benefit: 75% = \$449.30 85% = \$514.35		
	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: \$147.45 Benefit: 75% = \$110.60		
	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.)		
45853	Fee: \$918.70 Benefit: 75% = \$689.05 85% = \$834.00		
	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.)		
45855	Fee: \$421.50 Benefit: 75% = \$316.15 85% = \$358.30		
	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedure of that joint, not being a service associated with any other arthroscopic procedure of the temporomandibular joint (Anaes.) (Assist.)		
45857	Fee: \$674.20 Benefit: 75% = \$505.65 85% = \$589.50		
45859	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Subgroup applies (Anaes.) (Assist.)		

T8. SUF	SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$339.85	Benefit: 75% = \$254.90	85% = \$288.90	
	TEMPOROMAN techniques (Anae		rgical exploration of, with or without microsurgical	
45861	Fee: \$899.55	Benefit: 75% = \$674.70	85% = \$814.85	
		NDIBULAR JOINT, open su nicrosurgical techniques (Ar	rgical exploration of, with condylectomy or condylotomy, naes.) (Assist.)	
45863	Fee: \$997.20	Benefit: 75% = \$747.90	85% = \$912.50	
		ESIS, irrigation of temporor space(s) (Anaes.) (Assist.)	nandibular joint after insertion of 2 cannuli into the	
45865	Fee: \$299.60	Benefit: 75% = \$224.70	85% = \$254.70	
		NDIBULAR JOINT, synove s (Anaes.) (Assist.)	ctomy of, not being a service to which another item in this	
45867	Fee: \$322.05	Benefit: 75% = \$241.55	85% = \$273.75	
		g partial or total meniscecto	rigical exploration of, with or without meniscus or capsular my when performed, with or without microsurgical	
45869	Fee: \$1,225.30	Benefit: 75% = \$919.00	85% = \$1140.60	
			urgical exploration of, with meniscus, capsular and condylar echniques (Anaes.) (Assist.)	
45871	Fee: \$1,380.25	Benefit: 75% = \$1035.20	85% = \$1295.55	
	45869 and 45871		of, involving procedures to which items 45863, 45867, e use of tissue flaps, or cartilage graft, or allograft implants, naes.) (Assist.)	
45873	Fee: \$1,551.00	Benefit: 75% = \$1163.25	85% = \$1466.30	
			ation of, involving 1 or more of: repair of capsule, repair of rice to which another item in this Subgroup applies (Anaes.)	
45875	Fee: \$485.40	Benefit: 75% = \$364.05	85% = \$412.60	
		NDIBULAR JOINT, arthrod item in this Subgroup applic	esis of, with synovectomy if performed, not being a service es (Anaes.) (Assist.)	
45877	Fee: \$485.40	Benefit: 75% = \$364.05	85% = \$412.60	
	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.)			
45879	Fee: \$322.05	Benefit: 75% = \$241.55	85% = \$273.75	
	The treatment of or carbon dioxide	a premalignant lesion of the	oral mucosa by a treatment using cryotherapy, diathermy	
45882	Fee: \$44.35	Benefit: 75% = \$33.30	85% = \$37.70	
45885	Facial, mandibular or lingual artery or vein or artery and vein, ligation of, not being a service to which item 41707 applies (Anaes.) (Assist.)			

T8. SUF	SURGICAL OPERATIONS		13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	Fee: \$457.55	Benefit: 75% = \$343.2	0 85% = \$388.95	
	FOREIGN BOD techniques (Anac		facial region, deep, removal of using interventional imaging	
45888	Fee: \$426.45	Benefit: 75% = \$319.8	5 85% = \$362.50	
	SINGLE-STAGI (Assist.)	E LOCAL FLAP where inc	dicated, repair to 1 defect, using temporalis muscle (Anaes.)	
45891	Fee: \$621.30	Benefit: 75% = \$466.0	0 85% = \$536.60	
	FREE GRAFTIN (Anaes.)	NG, in the oral and maxillo	facial region, (mucosa or split skin) of a granulating area	
45894	Fee: \$211.10	Benefit: 75% = \$158.3	5 85% = \$179.45	
		EFT (congenital) unilateral ridge augmentation (Ana	al, grafting of, including plastic closure of associated oro- es.) (Assist.)	
45897	Fee: \$1,102.50	Benefit: 75% = \$826.9	0 85% = \$1017.80	
	MANDIBLE, fix	xation by intermaxillary wi	ring, excluding wiring for obesity	
45900	Fee: \$248.65	Benefit: 75% = \$186.5	0 85% = \$211.40	
	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.)			
45939	Fee: \$461.05	Benefit: 75% = \$345.8	0 85% = \$391.90	
	MANDIBLE, tre	eatment of a dislocation of,	requiring open reduction (Anaes.)	
45945	Fee: \$122.40	Benefit: 75% = \$91.80	85% = \$104.05	
	MAXILLA, unil	ateral or bilateral, treatmer	nt of fracture of, not requiring splinting	
	(See para TN.8.110 of explanatory notes to this Category)			
45975	Fee: \$133.20	Benefit: 75% = \$99.90 85% = \$113.25		
	MANDIBLE, treatment of fracture of, not requiring splinting			
45978	(See para TN.8.110 of explanatory notes to this Category) Fee: \$162.80 Benefit: 75% = \$122.10 85% = \$138.40			
	ZYGOMATIC E	BONE, treatment of fractur	e of, not requiring surgical reduction	
45981	(See para TN.8.11) Fee: \$88.30	0 of explanatory notes to this Benefit: 75% = \$66.25		
	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves requiring open reduction not involving plate(s) (Anaes.) (Assist.)			
45984	(See para TN.8.11) Fee: \$635.90	0 of explanatory notes to this Benefit: 75% = \$476.9		
		eatment of a complicated freduction not involving plat	racture of, involving viscera, blood vessels or nerves, e(s) (Anaes.) (Assist.)	
45987	(See para TN.8.11) Fee: \$635.90	0 of explanatory notes to this Benefit: 75% = \$476.9		
45990	MAXILLA, trea	tment of a complicated fra	cture of, involving viscera, blood vessels or nerves requiring	

T8. SUF	RGICAL OPERATIONS 1	13. PLASTIC AND RECONSTRUCTIVE SURGERY	
	open reduction involving the use of plate(s) (Ana	nes.) (Assist.)	
	(See para TN.8.110 of explanatory notes to this Categ Fee: \$868.60 Benefit: 75% = \$651.45 85		
	MANDIBLE, treatment of a complicated fractur requiring open reduction involving the use of pla		
45993	(See para TN.8.110 of explanatory notes to this Categ Fee: \$868.60 Benefit: 75% = \$651.45 85		
	MANDIBLE, treatment of a closed fracture of, i	nvolving a joint surface (Anaes.)	
	(See para TN.8.110 of explanatory notes to this Categ		
45996	Fee: \$246.25 Benefit: 75% = \$184.70 85		
18. SUF	RGICAL OPERATIONS	14. HAND SURGERY	
	Group T8. Surgical Operations		
	Subgrou	p 14. Hand Surgery	
	Note: Items 46300 to 46534 are restricted to sur	gery on the hand/s.	
	INTER-PHALANGEAL JOINT or METACAR synovectomy if performed (Anaes.) (Assist.)	POPHALANGEAL JOINT, arthrodesis of, with	
46300	Fee: \$348.95 Benefit: 75% = \$261.75		
	CARPOMETACARPAL JOINT, arthrodesis of,	with synovectomy if performed (Anaes.) (Assist.)	
46303	Fee: \$387.85 Benefit: 75% = \$290.90		
	INTERPHALANGEAL JOINT or METACARP and including tendon transfers or realignment on	OPHALANGEAL JOINT, interposition arthroplasty of the 1 ray (Anaes.) (Assist.)	
46306	Fee: \$542.90 Benefit: 75% = \$407.20		
	INTERPHALANGEAL JOINT OR METACAR traumatic deformity including tendon transfers o	POPHALANGEAL JOINT - volar plate arthroplasty for r realignment on the 1 ray (Anaes.) (Assist.)	
46307	Fee: \$542.90 Benefit: 75% = \$407.20		
	INTERPHALANGEAL JOINT or METACARP arthroplasty or hemiarthroplasty of, including as 1 joint (Anaes.) (Assist.)	OPHALANGEAL JOINT, total replacement sociated synovectomy, tendon transfer or realignment -	
46309	Fee: \$542.90 Benefit: 75% = \$407.20		
	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.)		
46312	Fee: \$698.10 Benefit: 75% = \$523.60		
46315	INTERPHALANGEAL JOINT or METACARP arthroplasty or hemiarthroplasty of, including as 3 joints (Anaes.) (Assist.)	OPHALANGEAL JOINT, total replacement sociated synovectomy, tendon transfer or realignment -	

T8. SUF	RGICAL OPERAT	ONS 14. HAND SURGERY
	Fee: \$930.75	Benefit: 75% = \$698.10
		GEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement miarthroplasty of, including associated synovectomy, tendon transfer or realignment - (Assist.)
46318	Fee: \$1,163.50	Benefit: 75% = \$872.65
		GEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement miarthroplasty of, including associated synovectomy, tendon transfer or realignment - Anaes.) (Assist.)
46321	Fee: \$1,396.20	Benefit: 75% = \$1047.15 85% = \$1311.50
		REPLACEMENT ARTHROPLASTY including associated tendon transfer or a performed (Anaes.) (Assist.)
46324	Fee: \$832.55	Benefit: 75% = \$624.45
		REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or including associated tendon transfer or realignment when performed (Anaes.) (Assist.)
46325	Fee: \$868.85	Benefit: 75% = \$651.65
	INTER-PHALA	IGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.)
46327	Fee: \$209.50	Benefit: 75% = \$157.15 85% = \$178.10
		NGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous or capsular hout arthrotomy (Anaes.) (Assist.)
46330	Fee: \$356.90	Benefit: 75% = \$267.70
		NGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using r implant (Anaes.) (Assist.)
46333	Fee: \$581.65	Benefit: 75% = \$436.25
		NGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, debridement of, not being a service associated with any procedure related to that joint
46336	Fee: \$271.50	Benefit: 75% = \$203.65 85% = \$230.80
	EXTENSOR TE	NDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.)
46339	Fee: \$480.75	Benefit: 75% = \$360.60 85% = \$408.65
	DISTAL RADIO (Anaes.) (Assist.	ULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of
46342	Fee: \$480.75	Benefit: 75% = \$360.60
	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.)	
46345	Fee: \$581.65	Benefit: 75% = \$436.25
	DIGIT, synovect	omy of flexor tendon or tendons - 1 digit (Anaes.)
46348	Fee: \$252.10	Benefit: 75% = \$189.10 85% = \$214.30
46351	- 	omy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY
	Fee: \$376.20	Benefit: 75% = \$282.15
	DIGIT, synovec	comy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.)
46354	Fee: \$504.10	Benefit: 75% = \$378.10
	DIGIT, synovec	comy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.)
46357	Fee: \$628.25	Benefit: 75% = \$471.20
	DIGIT, synovec	comy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.)
46360	Fee: \$756.30	Benefit: 75% = \$567.25
	TENDON SHEA	ATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS
46363	Fee: \$217.15	Benefit: 75% = \$162.90 85% = \$184.60
	DUPUYTREN'S	CONTRACTURE, subcutaneous fasciotomy for - each hand (Anaes.)
46366	Fee: \$131.90	Benefit: 75% = \$98.95 85% = \$112.15
	DUPUYTREN'S	CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.)
46369	Fee: \$217.15	Benefit: 75% = \$162.90 85% = \$184.60
	DUPUYTREN'S (Anaes.) (Assist.	CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand
46372	Fee: \$441.30	Benefit: 75% = \$331.00 85% = \$375.15
	DUPUYTREN'S hand (Anaes.) (A	CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 assist.)
46375	Fee: \$523.55	Benefit: 75% = \$392.70 85% = \$445.05
		CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of Anaes.) (Assist.)
46378	Fee: \$698.10	Benefit: 75% = \$523.60
		NGEAL JOINT, joint capsule release when performed in conjunction with operation for tracture - each procedure (Anaes.) (Assist.)
46381	Fee: \$310.20	Benefit: 75% = \$232.65
		imilar local flap procedure) when performed in conjunction with operation for tracture - 1 such procedure (Anaes.) (Assist.)
46384	Fee: \$310.20	Benefit: 75% = \$232.65
	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (Anaes.) (Assist.)	
46387	Fee: \$640.00	Benefit: 75% = \$480.00 85% = \$555.30
		CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - urrence in those rays (Anaes.) (Assist.)
46390	Fee: \$853.35	Benefit: 75% = \$640.05
46393	DUPUYTREN'S	CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of

T8. SUF	RGICAL OPERAT	ONS 14. HAND SURGERY
	nerves - operatio	n for recurrence in those rays (Anaes.) (Assist.)
	Fee: \$988.95	Benefit: 75% = \$741.75
		METACARPAL OF THE HAND, osteotomy or osteectomy of, and excluding services 933 or 47936 apply (Anaes.) (Assist.)
46396	Fee: \$339.85	Benefit: 75% = \$254.90 85% = \$288.90
	PHALANX OR (Assist.)	METACARPAL OF THE HAND, osteotomy of, with internal fixation (Anaes.)
46399	Fee: \$534.00	Benefit: 75% = \$400.50
	PHALANX or M graft material (A	ETACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of naes.) (Assist.)
46402	Fee: \$534.00	Benefit: 75% = \$400.50
		ETACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal ading obtaining of graft material (Anaes.) (Assist.)
46405	Fee: \$651.65	Benefit: 75% = \$488.75
	TENDON, reconstruction of, by tendon graft (Anaes.) (Assist.)	
46408	Fee: \$713.60 Benefit: 75% = \$535.20	
	FLEXOR TEND	ON PULLEY, reconstruction of, by graft (Anaes.) (Assist.)
46411	Fee: \$418.85	Benefit: 75% = \$314.15
	ARTIFICIAL TI (Assist.)	ENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (Anaes.)
46414	Fee: \$542.80	Benefit: 75% = \$407.10 85% = \$461.40
	TENDON transf	er for restoration of hand function, each transfer (Anaes.) (Assist.)
46417	Fee: \$504.10	Benefit: 75% = \$378.10
	EXTENSOR TE	NDON OF HAND OR WRIST, primary repair of, each tendon (Anaes.)
46420	Fee: \$210.95	Benefit: 75% = \$158.25 85% = \$179.35
	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (Anaes.) (Assist.)	
46423	Fee: \$337.40	Benefit: 75% = \$253.05 85% = \$286.80
	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (Anaes.) (Assist.)	
46426	Fee: \$348.95	Benefit: 75% = \$261.75
	FLEXOR TEND (Anaes.) (Assist.	ON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon
46429	Fee: \$426.55	Benefit: 75% = \$319.95 85% = \$362.60
	FLEXOR TEND	ON OF HAND, primary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)
46432	Fee: \$465.45	Benefit: 75% = \$349.10

T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY	
	FLEXOR TEND	OON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.)	
46435	Fee: \$542.90	Benefit: 75% = \$407.20	
	MALLET FING	ER, closed pin fixation of (Anaes.)	
46438	Fee: \$139.65	Benefit: 75% = \$104.75 85% = \$118.75	
	MALLET FING	ER, open repair of, including pin fixation when performed (Anaes.) (Assist.)	
46441	Fee: \$337.40	Benefit: 75% = \$253.05 85% = \$286.80	
		ER with intra articular fracture involving more than one third of base of terminal eduction (Anaes.) (Assist.)	
46442	Fee: \$289.65	Benefit: 75% = \$217.25	
	BOUTONNIER	E DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.)	
46444	Fee: \$504.10	Benefit: 75% = \$378.10	
	BOUTONNIER	E DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.)	
46447	Fee: \$628.25	Benefit: 75% = \$471.20	
	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.)		
46450	Fee: \$232.75	Benefit: 75% = \$174.60	
	FLEXOR TENE	OON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.)	
46453	Fee: \$387.85	Benefit: 75% = \$290.90	
	FINGER, percutaneous tenotomy of (Anaes.)		
46456	Fee: \$100.85	Benefit: 75% = \$75.65 85% = \$85.75	
	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.)		
46459	Fee: \$193.90	Benefit: 75% = \$145.45 85% = \$164.85	
	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.)		
46462	Fee: \$310.20	Benefit: 75% = \$232.65 85% = \$263.70	
	AMPUTATION	of a supernumerary complete digit (Anaes.)	
46464	Fee: \$232.75	Benefit: 75% = \$174.60 85% = \$197.85	
	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.)		
46465	Fee: \$232.75	Benefit: 75% = \$174.60 85% = \$197.85	
	AMPUTATION tissue cover (An	of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46468	Fee: \$407.20	Benefit: 75% = \$305.40	
	AMPUTATION tissue cover (An	of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46471	Fee: \$581.65	Benefit: 75% = \$436.25 85% = \$496.95	

T8. SUF	RGICAL OPERAT	IONS 14. HAND SURGERY	
	AMPUTATION tissue cover (An	of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft aes.) (Assist.)	
46474	Fee: \$756.30	Benefit: 75% = \$567.25	
	AMPUTATION tissue cover (An	of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft nes.) (Assist.)	
46477	Fee: \$930.75	Benefit: 75% = \$698.10	
		of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and sue cover, including metacarpal (Anaes.) (Assist.)	
46480	Fee: \$387.85	Benefit: 75% = \$290.90 85% = \$329.70	
	REVISION of A	MPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.)	
46483	Fee: \$310.20	Benefit: 75% = \$232.65 85% = \$263.70	
		orate reconstruction of nail bed laceration using magnification, undertaken in the of a hospital (Anaes.)	
46486	Fee: \$232.75	Benefit: 75% = \$174.60	
	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital (Anaes.) (Assist.)		
46489	Fee: \$271.50	Benefit: 75% = \$203.65	
		E OF DIGITS OF HAND, flexor or extensor, correction of, involving tissues deeper ocutaneous tissue (Anaes.) (Assist.)	
46492	Fee: \$372.35	Benefit: 75% = \$279.30	
	GANGLION OF HAND, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.)		
46494	Fee: \$226.80	Benefit: 75% = \$170.10 85% = \$192.80	
	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.)		
46495	Fee: \$209.50	Benefit: 75% = \$157.15 85% = \$178.10	
		FLEXOR TENDON SHEATH, excision of, other than a service associated with a item 30107 applies (Anaes.)	
46498	Fee: \$226.80	Benefit: 75% = \$170.10 85% = \$192.80	
	GANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated with a service to which item 30107 applies (Anaes.) (Assist.)		
46500	Fee: \$271.50	Benefit: 75% = \$203.65 85% = \$230.80	
		VOLAR WRIST JOINT, excision of, other than a service associated with a service to 7 applies (Anaes.) (Assist.)	
46501	Fee: \$339.45	Benefit: 75% = \$254.60 85% = \$288.55	
		SANGLION OF DORSAL WRIST JOINT, excision of, other than a service associated which item 30107 applies (Anaes.) (Assist.)	
46502	Fee: \$312.40	Benefit: 75% = \$234.30 85% = \$265.55	

T8. SUI	RGICAL OPERAT	ONS 14. HAND SURGER	
		ANGLION OF VOLAR WRIST JOINT, excision of, other than a service associated which item 30107 applies (Anaes.) (Assist.)	
46503	Fee: \$390.20	Benefit: 75% = \$292.65 85% = \$331.70	
	NEUROVASCU	AR ISLAND FLAP, for pulp innervation (Anaes.) (Assist.)	
46504	Fee: \$1,140.10	Benefit: 75% = \$855.10 85% = \$1055.40	
	DIGIT OR RAY	transposition or transfer of, on vascular pedicle, complete procedure (Anaes.) (Assist.)	
46507	Fee: \$1,326.40	Benefit: 75% = \$994.80	
	MACRODACT	LY, surgical reduction of enlarged elements - each digit (Anaes.) (Assist.)	
46510	Fee: \$361.95	Benefit: 75% = \$271.50	
	DIGITAL NAII (Anaes.)	OF FINGER OR THUMB, removal of, not being a service to which item 46516 applie	
46513	Fee: \$58.25	Benefit: 75% = \$43.70 85% = \$49.55	
	DIGITAL NAII	OF FINGER OR THUMB, removal of, in the operating theatre of a hospital (Anaes.)	
46516	Fee: \$116.35	Benefit: 75% = \$87.30	
	MIDDLE PALM aftercare) (Anae	AR, THENAR OR HYPOTHENAR SPACES OF HAND, drainage of (excluding)	
46519	Fee: \$145.65	Benefit: 75% = \$109.25 85% = \$123.85	
	FLEXOR TENI (Anaes.) (Assist	ON SHEATH OF FINGER OR THUMB, open operation and drainage for infection	
46522	Fee: \$434.35	Benefit: 75% = \$325.80	
		FECTION, PARONYCHIA OF HAND, incision for, when performed in an operating al, not being a service to which another item in this Group applies (excluding after-	
46525	Fee: \$58.25	Benefit: 75% = \$43.70 85% = \$49.55	
	INGROWING NAIL OF FINGER OR THUMB, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (Anaes.)		
46528	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60	
	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.)		
46531	Fee: \$87.80	Benefit: 75% = \$65.85 85% = \$74.65	
	NAIL PLATE I	JURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.)	
46534	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45	
T8. SUI	RGICAL OPERAT	ONS 15. ORTHOPAEDIO	
	Group T8. Surg	al Operations	
		Subgroup 15. Orthopaedic	

	IONS 15. ORTHOPAEDIC	
	TREATMENT OF DISLOCATIONS	
MANDIBLE, tre	eatment of dislocation of, by closed reduction (Anaes.)	
Fee: \$72.90	Benefit: 75% = \$54.70 85% = \$62.00	
	atment of dislocation of, by closed reduction (Anaes.)	
Fee: \$87.45	Benefit: 75% = \$65.60 85% = \$74.35	
	atment of dislocation of, by open reduction (Anaes.)	
Fee: \$175.55	Benefit: 75% = \$131.70 85% = \$149.25	
SHOULDER, tre	eatment of dislocation of, requiring general anaesthesia, not being a service to which	
Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60	
SHOULDER, tre (Assist.)	eatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.)	
Fee: \$349.40	Benefit: 75% = \$262.05	
SHOULDER, tre	eatment of dislocation of, not requiring general anaesthesia	
Fee: \$87.45	Benefit: 75% = \$65.60 85% = \$74.35	
ELBOW, treatm	ent of dislocation of, by closed reduction (Anaes.)	
Fee: \$203.75	Benefit: 75% = \$152.85 85% = \$173.20	
ELBOW, treatm	ent of dislocation of, by open reduction (Anaes.) (Assist.)	
Fee: \$271.80	Benefit: 75% = \$203.85	
RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.)		
Fee: \$203.75	Benefit: 75% = \$152.85 85% = \$173.20	
RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.)		
Fee: \$271.80	Benefit: 75% = \$203.85	
CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)		
Fee: \$203.75	Benefit: 75% = \$152.85 85% = \$173.20	
	RPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of y open reduction (Anaes.) (Assist.)	
Fee: \$271.80	Benefit: 75% = \$203.85 85% = \$231.05	
INTERPHALAN	NGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	
Fee: \$87.45	Benefit: 75% = \$65.60 85% = \$74.35	
INTERPHALAN	NGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)	
Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90	
	Fee: \$72.90 CLAVICLE, treater Fee: \$87.45 CLAVICLE, treater Fee: \$175.55 SHOULDER, treater 47012 applier Fee: \$174.80 SHOULDER, treater (Assist.) Fee: \$349.40 SHOULDER, treater Fee: \$203.75 ELBOW, treatmer Fee: \$203.75 ELBOW, treatmer Fee: \$271.80 RADIOULNAR being a service and Fee: \$203.75 RADIOULNAR being a service and Fee: \$271.80 CARPUS, or CA dislocation of, by Fee: \$203.75 CARPUS, or CA dislocation of, by Fee: \$271.80 INTERPHALAN Fee: \$87.45 INTERPHALAN	

T8. SUF	RGICAL OPERA	TIONS 15. ORTHOPAEDIC	
	METACARPO	PHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.)	
47042	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90	
	METACARPO	PHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.)	
47045	Fee: \$155.45	Benefit: 75% = \$116.60 85% = \$132.15	
	HIP, treatment	of dislocation of, by closed reduction (Anaes.)	
47048	Fee: \$334.95	Benefit: 75% = \$251.25 85% = \$284.75	
	HIP, treatment	of dislocation of, by open reduction (Anaes.) (Assist.)	
47051	Fee: \$446.50	Benefit: 75% = \$334.90	
		nt of dislocation of, by closed reduction (Anaes.) (Assist.)	
47054	Fee: \$334.95	Benefit: 75% = \$251.25 85% = \$284.75	
		tment of dislocation of, by closed reduction (Anaes.)	
47057	Fee: \$131.00	Benefit: 75% = \$98.25 85% = \$111.35	
17007		tment of dislocation of, by open reduction (Anaes.)	
47060	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60	
17000		RSUS, treatment of dislocation of, by closed reduction (Anaes.)	
47063	Fee: \$262.10	Benefit: 75% = \$196.60 85% = \$222.80	
47003	•	LE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.)	
47066	Fee: \$349.40	Benefit: 75% = \$262.05	
47000	TOE, treatment of dislocation of, by closed reduction (Anaes.)		
47069	Fee: \$72.90	Benefit: 75% = \$54.70 85% = \$62.00	
47007	TOE, treatment of dislocation of, by open reduction (Anaes.)		
47072	Fee: \$96.95 Benefit: 75% = \$72.75 85% = \$82.45		
47072	Pec. \$70.73	TREATMENT OF FRACTURES	
		or proximal, treatment of fracture of, by closed reduction, requiring anaesthesia, not same occasion as a service described in item 47304, 47307, 47310, 47313, 47316 or	
47301	(See para TN.8.12 Fee: \$89.50	24 of explanatory notes to this Category) Benefit: 75% = \$67.15 85% = \$76.10	
	Metacarpal, treatment of fracture of, by closed reduction, requiring anaesthesia, not provide same occasion as a service described in item 47301, 47307, 47310, 47313, 47316 or 4731		
47304	(See para TN.8.12 Fee: \$102.00	24 of explanatory notes to this Category) Benefit: 75% = \$76.50	
	Phalanx or meta (Anaes.) (Assist	carpal, treatment of fracture of, by closed reduction with percutaneous K wire fixation .)	
47307	(See para TN.8.1: Fee: \$206.25	24 of explanatory notes to this Category) Benefit: 75% = \$154.70	

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	Phalanx or metacarpal, treatment of fracture of, by open reduction with f	ixation (Anaes.) (Assist.)
47310	(See para TN.8.124 of explanatory notes to this Category) Fee: \$340.35 Benefit: 75% = \$255.30	
	Phalanx or metacarpal, treatment of intra articular fracture of, by closed wire fixation (Anaes.) (Assist.)	reduction with percutaneous K
47313	(See para TN.8.124 of explanatory notes to this Category) Fee: \$330.00 Benefit: 75% = \$247.50	
	Phalanx or metacarpal, treatment of intra articular fracture of, by open re provided on the same occasion as a service to which item 47319 applies	
47316	(See para TN.8.124 of explanatory notes to this Category) Fee: \$654.85 Benefit: 75% = \$491.15	
	Middle phalanx, proximal end, treatment of intra articular fracture of, by not provided on the same occasion as a service to which item 47316 appl	
47319	(See para TN.8.124 of explanatory notes to this Category) Fee: \$670.30 Benefit: 75% = \$502.75	
	CARPUS (excluding scaphoid), treatment of fracture of, not being a serv (Anaes.)	vice to which item 47351 applies
47348	Fee: \$96.95 Benefit: 75% = \$72.75 85% = \$82.45	
	CARPUS (excluding scaphoid), treatment of fracture of, by open reducti	on (Anaes.)
47351	Fee: \$242.85 Benefit: 75% = \$182.15 85% = \$206.45	
	CARPAL SCAPHOID, treatment of fracture of, not being a service to w (Anaes.)	hich item 47357 applies
47354	Fee: \$174.80 Benefit: 75% = \$131.10 85% = \$148.60	
	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anat	es.) (Assist.)
47357	Fee: \$388.30 Benefit: 75% = \$291.25 85% = \$330.10	
	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, than a service associated with a service to which item 47362, 47364, 473	•
47361	(See para TN.8.124 of explanatory notes to this Category) Fee: \$135.95 Benefit: 75% = \$102.00 85% = \$115.60	
	Radius or ulna, or radius and ulna, distal end of, treatment of fracture of, general or major regional anaesthesia, but excluding local infiltration, otl with a service to which item 47361, 47364, 47367, 47370 or 47373 appli	her than a service associated
47362	(See para TN.8.124 of explanatory notes to this Category) Fee: \$203.75 Benefit: 75% = \$152.85 85% = \$173.20	
	Radius or ulna, distal end of, not involving joint surface, treatment of fra fixation, other than a service associated with a service to which item 473 (Assist.)	
47364	(See para TN.8.124 of explanatory notes to this Category) Fee: \$288.75 Benefit: 75% = \$216.60	
47367	Radius, distal end of, treatment of fracture of, by closed reduction with p	percutaneous fixation, other than

a service associate		
	d with a service to which item 47361 or 47	362 applies (Anaes.) (Assist.)
(See para TN.8.124 o Fee: \$230.60	of explanatory notes to this Category) Benefit: 75% = \$172.95	
(See para TN.8.124 o Fee: \$418.70	of explanatory notes to this Category) Benefit: 75% = \$314.05	
(See para TN.8.124 (Fee: \$299.05	of explanatory notes to this Category) Benefit: 75% = \$224.30	
		st immobilisation, not being a service to
Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60	
		osed reduction undertaken in the operating
Fee: \$262.10	Benefit: 75% = \$196.60	
RADIUS OR ULN	IA, shaft of, treatment of fracture of, by ope	en reduction (Anaes.) (Assist.)
Fee: \$349.40	Benefit: 75% = \$262.05	
ulnar joint or prox	imal radio-humeral joint (Galeazzi or Mont	teggia injury), by closed reduction
Fee: \$300.85	Benefit: 75% = \$225.65	
ulnar joint or prox	imal radio-humeral joint (Galeazzi or Mont	
Fee: \$485.40	Benefit: 75% = \$364.05	
		cast immobilisation, not being a service to
Fee: \$281.45	Benefit: 75% = \$211.10 85% = \$239.25	
		closed reduction undertaken in the
Fee: \$422.35	Benefit: 75% = \$316.80	
RADIUS AND UI	LNA, shafts of, treatment of fracture of, by	open reduction (Anaes.) (Assist.)
Fee: \$563.05	Benefit: 75% = \$422.30	
OLECRANON, tre	eatment of fracture of, not being a service	to which item 47399 applies (Anaes.)
Fee: \$194.05	Benefit: 75% = \$145.55 85% = \$164.95	
		Anaes.) (Assist.)
	Radius, distal end service associated (See para TN.8.124 of Fee: \$418.70 Ulna, distal end of service associated (See para TN.8.124 of Fee: \$299.05 RADIUS OR ULN which item 47381, Fee: \$174.80 RADIUS OR ULN theatre of a hospital fee: \$262.10 RADIUS OR ULN ulnar joint or proxi undertaken in the of fee: \$349.40 RADIUS OR ULN ulnar joint or proxi undertaken in the of fee: \$300.85 RADIUS OR ULN ulnar joint or proxi fixation (Anaes.) (An	Radius, distal end of, treatment of intra articular fracture of, bservice associated with a service to which item 47361 or 4736 (See para TN.8.124 of explanatory notes to this Category) Fee: \$418.70 Benefit: 75% = \$314.05 Ulna, distal end of, treatment of intra articular fracture of, by service associated with a service to which item 47361 or 4736 (See para TN.8.124 of explanatory notes to this Category) Fee: \$299.05 Benefit: 75% = \$224.30 RADIUS OR ULNA, shaft of, treatment of fracture of, by cas which item 47381, 47384, 47385 or 47386 applies (Anaes.) Fee: \$174.80 Benefit: 75% = \$131.10 85% = \$148.60 RADIUS OR ULNA, shaft of, treatment of fracture of, by clotheatre of a hospital (Anaes.) Fee: \$262.10 Benefit: 75% = \$196.60 RADIUS OR ULNA, shaft of, treatment of fracture of, by operating the proximal radio-humeral joint (Galeazzi or Monundertaken in the operating theatre of a hospital (Anaes.) (As Fee: \$300.85 Benefit: 75% = \$225.65 RADIUS OR ULNA, shaft of, treatment of fracture of, in conclunar joint or proximal radio-humeral joint (Galeazzi or Monundertaken in the operating theatre of a hospital (Anaes.) (As Fee: \$485.40 Benefit: 75% = \$225.65 RADIUS OR ULNA, shaft of, treatment of fracture of, in conclunar joint or proximal radio-humeral joint (Galeazzi or Monundertaken in the operating theatre of a hospital (Anaes.) Fee: \$485.40 Benefit: 75% = \$364.05 RADIUS AND ULNA, shafts of, treatment of fracture of, by which item 47390 or 47393 applies (Anaes.) (Assist.) Fee: \$281.45 Benefit: 75% = \$211.10 85% = \$239.25 RADIUS AND ULNA, shafts of, treatment of fracture of, by operating theatre of a hospital (Anaes.) Fee: \$422.35 Benefit: 75% = \$316.80 RADIUS AND ULNA, shafts of, treatment of fracture of, by operating theatre of a hospital (Anaes.) Fee: \$422.35 Benefit: 75% = \$316.80 RADIUS AND ULNA, shafts of, treatment of fracture of, by operating theatre of a hospital (Anaes.)

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	Fee: \$388.30	Benefit: 75% = \$291.25
	OLECRANON, tendon (Anaes.)	treatment of fracture of, involving excision of olecranon fragment and reimplantation of (Assist.)
47402	Fee: \$291.15	Benefit: 75% = \$218.40 85% = \$247.50
	RADIUS, treatm	ent of fracture of head or neck of, closed reduction of (Anaes.)
47405	Fee: \$194.05	Benefit: 75% = \$145.55 85% = \$164.95
		nent of fracture of head or neck of, open reduction of, including internal fixation and performed (Anaes.) (Assist.)
47408	Fee: \$388.30	Benefit: 75% = \$291.25
	HUMERUS, trea (Anaes.)	atment of fracture of tuberosity of, not being a service to which item 47417 applies
47411	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90
	HUMERUS, trea	atment of fracture of tuberosity of, by open reduction (Anaes.)
47414	Fee: \$233.05	Benefit: 75% = \$174.80 85% = \$198.10
	HUMERUS, trea	atment of fracture of tuberosity of, and associated dislocation of shoulder, by closed s.) (Assist.)
47417	Fee: \$271.80	Benefit: 75% = \$203.85 85% = \$231.05
	HUMERUS, trea reduction (Anaes	atment of fracture of tuberosity of, and associated dislocation of shoulder, by open s.) (Assist.)
47420	Fee: \$534.00	Benefit: 75% = \$400.50
	HUMERUS, pro 47432 applies (A	eximal, treatment of fracture of, not being a service to which item 47426, 47429 or Anaes.)
47423	Fee: \$223.25	Benefit: 75% = \$167.45 85% = \$189.80
	HUMERUS, pro of a hospital (Ar	eximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre tases.)
47426	Fee: \$334.95	Benefit: 75% = \$251.25
	HUMERUS, pro	oximal, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47429	Fee: \$446.50	Benefit: 75% = \$334.90
	HUMERUS, pro	eximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.)
47432	Fee: \$558.20	Benefit: 75% = \$418.65
	HUMERUS, pro	eximal, treatment of fracture of, and associated dislocation of shoulder, by closed s.) (Assist.)
47435	Fee: \$427.20	Benefit: 75% = \$320.40 85% = \$363.15
	HUMERUS, pro	eximal, treatment of fracture of, and associated dislocation of shoulder, by open s.) (Assist.)
47438	Fee: \$679.75	Benefit: 75% = \$509.85
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by	

T8. SUF	RGICAL OPERAT	ONS 15. ORTHOPAEDIC
	open reduction (A	Anaes.) (Assist.)
	Fee: \$849.50	Benefit: 75% = \$637.15
	HUMERUS, sha (Anaes.)	ft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies
47444	Fee: \$233.05	Benefit: 75% = \$174.80 85% = \$198.10
	HUMERUS, sha a hospital (Anaes	ft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of s.)
47447	Fee: \$349.40	Benefit: 75% = \$262.05
	HUMERUS, sha	ft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)
47450	Fee: \$466.10	Benefit: 75% = \$349.60
	HUMERUS, sha	ft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.)
47451	Fee: \$561.80	Benefit: 75% = \$421.35
		al, (supracondylar or condylar), treatment of fracture of, not being a service to which 459 applies (Anaes.) (Assist.)
47453	Fee: \$271.80	Benefit: 75% = \$203.85 85% = \$231.05
		al (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken heatre of a hospital (Anaes.)
47456	Fee: \$407.90	Benefit: 75% = \$305.95
		al (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken heatre of a hospital (Anaes.) (Assist.)
47459	Fee: \$543.75	Benefit: 75% = \$407.85
	CLAVICLE, trea	tment of fracture of, not being a service to which item 47465 applies (Anaes.)
47462	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90
	CLAVICLE, trea	ttment of fracture of, by open reduction (Anaes.) (Assist.)
47465	Fee: \$233.05	Benefit: 75% = \$174.80 85% = \$198.10
	STERNUM, trea	tment of fracture of, not being a service to which item 47467 applies (Anaes.)
47466	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90
	STERNUM, treatment of fracture of, by open reduction (Anaes.)	
47467	Fee: \$233.05	Benefit: 75% = \$174.80
	SCAPULA, neck	or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47468	Fee: \$446.50	Benefit: 75% = \$334.90 85% = \$379.55
), treatment of fracture of - each attendance
47471	Fee: \$44.35	Benefit: 75% = \$33.30 85% = \$37.70
., ,,,		treatment of fracture of, not involving disruption of pelvic ring or acetabulum
47474	Fee: \$194.05	Benefit: 75% = \$145.55 85% = \$164.95
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T8. SUF	RGICAL OPERATI	ONS	15. ORTHOPAEDIC
	PELVIC RING,	reatment of fracture of, with disruption of	pelvic ring or acetabulum
47477	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.4	.5
	PELVIC RING, 1	reatment of fracture of, requiring traction	(Anaes.) (Assist.)
47480	Fee: \$485.40	Benefit: 75% = \$364.05	
	PELVIC RING,	reatment of fracture of, requiring control	by external fixation (Anaes.) (Assist.)
47483	Fee: \$582.50	Benefit: 75% = \$436.90	
		reatment of fracture of, by open reduction g diastasis of pubic symphysis (Anaes.) (and involving internal fixation of anterior Assist.)
47486	Fee: \$970.85	Benefit: 75% = \$728.15	
		reatment of fracture of, by open reduction ng sacro-iliac joint), with or without fixati	and involving internal fixation of posterior on of anterior segment (Anaes.) (Assist.)
47489	Fee: \$1,456.30	Benefit: 75% = \$1092.25	
	ACETABULUM	, treatment of fracture of, and associated of	dislocation of hip (Anaes.)
47492	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.4	5
	ACETABULUM (Assist.)	, treatment of fracture of, and associated of	dislocation of hip, requiring traction (Anaes.)
47495	Fee: \$485.40	Benefit: 75% = \$364.05 85% = \$412.6	50
		, treatment of fracture of, and associated caction (Anaes.) (Assist.)	lislocation of hip, requiring internal fixation,
47498	Fee: \$728.10	Benefit: 75% = \$546.10	
	including any ost	, treatment of single column fracture of, becomy, osteectomy or capsulotomy requises to which item 47933 or 47936 apply (A.	red for exposure and subsequent repair, and
47501	Fee: \$970.85	Benefit: 75% = \$728.15	
	any osteotomy, o		n reduction and internal fixation, including posure and subsequent repair, and excluding sist.)
47504	Fee: \$1,456.30	Benefit: 75% = \$1092.25 85% = \$137	1.60
	any osteotomy, o		pen reduction and internal fixation, including posure and subsequent repair, and excluding sist.)
47507	Fee: \$1,456.30	Benefit: 75% = \$1092.25	
	including any ost	, treatment of double column fracture of, leotomy, osteectomy or capsulotomy requises to which item 47933 or 47936 apply (A	red for exposure and subsequent repair, and
47510	Fee: \$1,456.30	Benefit: 75% = \$1092.25	
47513		OINT DISRUPTION, treatment of, require service to which items 47501 to 47510 ap	

T8. SUR	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	Fee: \$388.30	Benefit: 75% = \$291.25
	FEMUR, treatme	ent of fracture of, by closed reduction or traction (Anaes.) (Assist.)
47516	Fee: \$446.50	Benefit: 75% = \$334.90 85% = \$379.55
	FEMUR, treatme	ent of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.)
47519	Fee: \$893.25	Benefit: 75% = \$669.95
	FEMUR, treatme	ent of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.)
47522	Fee: \$776.80	Benefit: 75% = \$582.60
	FEMUR, treatme	ent of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.)
47525	Fee: \$893.25	Benefit: 75% = \$669.95
	FEMUR, treatme	ent of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)
47528	Fee: \$776.80	Benefit: 75% = \$582.60
		ent of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.)
47531	Fee: \$990.25	Benefit: 75% = \$742.70
		ar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring with or without internal fixation of 1 or more osteochondral fragments (Anaes.)
47534	Fee: \$1,116.50	Benefit: 75% = \$837.40
		ar region of, treatment of fracture of, requiring internal fixation of 1 or more agments, not being a service associated with a service to which item 47534 applies
47537	Fee: \$446.50	Benefit: 75% = \$334.90 85% = \$379.55
	HIP SPICA OR	SHOULDER SPICA, application of, as an independent procedure (Anaes.)
47540	Fee: \$223.25	Benefit: 75% = \$167.45 85% = \$189.80
	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.)	
47543	Fee: \$233.05	Benefit: 75% = \$174.80 85% = \$198.10
	TIBIA, plateau o	f, treatment of medial or lateral fracture of, by closed reduction (Anaes.)
47546	Fee: \$349.40	Benefit: 75% = \$262.05 85% = \$297.00
	TIBIA, plateau o	f, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.)
47549	Fee: \$466.10	Benefit: 75% = \$349.60
		f, treatment of both medial and lateral fractures of, not being a service to which item applies (Anaes.) (Assist.)
47552	Fee: \$388.30	Benefit: 75% = \$291.25 85% = \$330.10
	TIBIA, plateau o	f, treatment of both medial and lateral fractures of, by closed reduction (Anaes.)
47555	Fee: \$582.50	Benefit: 75% = \$436.90

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
	TIBIA, plateau of	, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.)
47558	Fee: \$776.80	Benefit: 75% = \$582.60
		reatment of fracture of, by cast immobilisation, not being a service to which item 570 or 47573 applies (Anaes.)
47561	Fee: \$281.45	Benefit: 75% = \$211.10 85% = \$239.25
	TIBIA, shaft of, tr fracture (Anaes.)	reatment of fracture of, by closed reduction, with or without treatment of fibular
47564	Fee: \$422.35	Benefit: 75% = \$316.80 85% = \$359.00
	TIBIA, shaft of, tr	reatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.)
47565	Fee: \$734.65	Benefit: 75% = \$551.00
	TIBIA, shaft of, tr	reatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.)
47566	Fee: \$936.45	Benefit: 75% = \$702.35
	TIBIA, shaft of, tr fibular fracture (A	reatment of intra-articular fracture of, by closed reduction, with or without treatment of maes.) (Assist.)
47567	Fee: \$490.20	Benefit: 75% = \$367.65 85% = \$416.70
	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fractur (Anaes.) (Assist.)	
47570	Fee: \$563.05	Benefit: 75% = \$422.30 85% = \$478.60
	TIBIA, shaft of, tr fibula fracture (Ar	reatment of intra-articular fracture of, by open reduction, with or without treatment of naes.) (Assist.)
47573	Fee: \$703.85	Benefit: 75% = \$527.90
	FIBULA, treatment	nt of fracture of (Anaes.)
47576	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90
	PATELLA, treatm	nent of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.)
47579	Fee: \$165.05	Benefit: 75% = \$123.80 85% = \$140.30
	PATELLA, treatm (Assist.)	nent of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.)
47582	Fee: \$339.85	Benefit: 75% = \$254.90
	PATELLA, treatm	nent of fracture of, by internal fixation (Anaes.) (Assist.)
47585	Fee: \$437.00	Benefit: 75% = \$327.75
	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.)	
47588	Fee: \$1,359.00	Benefit: 75% = \$1019.25
47591		atment of fracture of, by internal fixation of intra-articular fractures of femoral l articular surfaces and requiring repair or reconstruction of 1 or more ligaments

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
	Fee: \$1,650.65	Benefit: 75% = \$1238.00
	ANKLE JOINT,	reatment of fracture of, not being a service to which item 47597 applies (Anaes.)
47594	Fee: \$223.25	Benefit: 75% = \$167.45 85% = \$189.80
	ANKLE JOINT,	reatment of fracture of, by closed reduction (Anaes.)
47597	Fee: \$334.95	Benefit: 75% = \$251.25 85% = \$284.75
	ANKLE JOINT, 1 (Anaes.) (Assist.)	reatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis
47600	Fee: \$446.50	Benefit: 75% = \$334.90
	ANKLE JOINT, diastasis (Anaes.)	reatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or (Assist.)
47603	Fee: \$582.50	Benefit: 75% = \$436.90
		OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, pplies, with or without dislocation (Anaes.)
47606	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45
	CALCANEUM C (Anaes.) (Assist.)	OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation
47609	Fee: \$364.10	Benefit: 75% = \$273.10 85% = \$309.50
	CALCANEUM C dislocation (Anae	OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without s.) (Assist.)
47612	Fee: \$422.35	Benefit: 75% = \$316.80 85% = \$359.00
	CALCANEUM C (Anaes.) (Assist.)	OR TALUS, treatment of fracture of, by open reduction, with or without dislocation
47615	Fee: \$485.40	Benefit: 75% = \$364.05 85% = \$412.60
	CALCANEUM C dislocation (Anae	OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without s.) (Assist.)
47618	Fee: \$606.80	Benefit: 75% = \$455.10
	TARSO-METAT dislocation (Anae	ARSAL, treatment of intra-articular fracture of, by closed reduction, with or without s.) (Assist.)
47621	Fee: \$422.35	Benefit: 75% = \$316.80 85% = \$359.00
	TARSO-METAT (Anaes.) (Assist.)	ARSAL, treatment of fracture of, by open reduction, with or without dislocation
47624	Fee: \$582.50	Benefit: 75% = \$436.90
	TARSUS (exclud	ing calcaneum or talus), treatment of fracture of (Anaes.)
47627	Fee: \$165.05	Benefit: 75% = \$123.80 85% = \$140.30
	TARSUS (exclud dislocation (Anae	ing calcaneum or talus), treatment of fracture of, by open reduction, with or without s.) (Assist.)
47630	Fee: \$349.40	Benefit: 75% = \$262.05 85% = \$297.00

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	METATARSAL	, 1 of, treatment of fracture of (Anaes.)
47633	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90
	METATARSAL	, 1 of, treatment of fracture of, by closed reduction (Anaes.)
47636	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60
	METATARSAL	, 1 of, treatment of fracture of, by open reduction (Anaes.)
47639	Fee: \$233.05	Benefit: 75% = \$174.80 85% = \$198.10
	METATARSAL	S, 2 of, treatment of fracture of (Anaes.)
47642	Fee: \$155.45	Benefit: 75% = \$116.60 85% = \$132.15
	METATARSAL	S, 2 of, treatment of fracture of, by closed reduction (Anaes.)
47645	Fee: \$233.05	Benefit: 75% = \$174.80 85% = \$198.10
	METATARSAL	S, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47648	Fee: \$310.45	Benefit: 75% = \$232.85
	METATARSAL	S, 3 or more of, treatment of fracture of (Anaes.)
47651	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45
	METATARSAL	S, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.)
47654	Fee: \$364.10	Benefit: 75% = \$273.10 85% = \$309.50
	· ·	S, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.)
47657	Fee: \$485.40	Benefit: 75% = \$364.05
		GREAT TOE, treatment of fracture of, by closed reduction (Anaes.)
47663	Fee: \$145.65	Benefit: 75% = \$109.25 85% = \$123.85
		GREAT TOE, treatment of fracture of, by open reduction (Anaes.)
47666	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45
		ΓΟΕ (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.)
47672	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90
		TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction
	(Anaes.)	
47678	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60
	BONE GRAFT, small quantity (A	harvesting of, via separate incision, in conjunction with another service - autogenous - Anaes.)
47726	Fee: \$145.65	Benefit: 75% = \$109.25
	BONE GRAFT, large quantity (A	harvesting of, via separate incision, in conjunction with another service - autogenous - naes.)
47729	Fee: \$242.85	Benefit: 75% = \$182.15
47732	VASCULARISE	ED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service

T8. SUF	RGICAL OPERATIO	NS 15. ORTHOPAEDIC	
	(Anaes.) (Assist.)		
	Fee: \$388.30	Benefit: 75% = \$291.25	
	NASAL BONES, t	reatment of fracture of, not being a service to which item 47738 or 47741 applies -	
47735	Fee: \$44.40	Benefit: 75% = \$33.30 85% = \$37.75	
	NASAL BONES, t	reatment of fracture of, by reduction (Anaes.)	
47738	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45	
	NASAL BONES, t	reatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.)	
47741	Fee: \$495.35	Benefit: 75% = \$371.55	
	MAXILLA, treatmexternal fixation (A	ent of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or Anaes.) (Assist.)	
47753	Fee: \$419.35	Benefit: 75% = \$314.55	
	MANDIBLE, treat external fixation (A	ment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or Anaes.) (Assist.)	
47756	Fee: \$419.35	Benefit: 75% = \$314.55	
	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral other approach (Anaes.)		
47762	Fee: \$246.25	Benefit: 75% = \$184.70 85% = \$209.35	
		NE, treatment of fracture of, requiring surgical reduction and involving internal or 1 site (Anaes.) (Assist.)	
47765	Fee: \$404.35	Benefit: 75% = \$303.30	
	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.)		
47768	Fee: \$495.35	Benefit: 75% = \$371.55	
		NE, treatment of fracture of, requiring surgical reduction and involving internal or both at 3 sites (Anaes.) (Assist.)	
47771	Fee: \$569.10	Benefit: 75% = \$426.85	
	MAXILLA, treatm	ent of fracture of, requiring open operation (Anaes.) (Assist.)	
47774	Fee: \$449.25	Benefit: 75% = \$336.95	
	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.)		
47777	Fee: \$449.25	Benefit: 75% = \$336.95	
	MAXILLA, treatm (Anaes.) (Assist.)	ent of fracture of, requiring open reduction and internal fixation not involving plate(s)	
47780	Fee: \$584.05	Benefit: 75% = \$438.05	
	MANDIBLE, treat plate(s) (Anaes.) (A	ment of fracture of, requiring open reduction and internal fixation not involving Assist.)	
47783	Fee: \$584.05	Benefit: 75% = \$438.05 85% = \$499.35	

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	MAXILLA, treat (Anaes.) (Assist.)	tment of fracture of, requiring open reduction and internal fixation involving plate(s)
47786	Fee: \$741.20	Benefit: 75% = \$555.90
	MANDIBLE, tre (Anaes.) (Assist.)	eatment of fracture of, requiring open reduction and internal fixation involving plate(s)
47789	Fee: \$741.20	Benefit: 75% = \$555.90
		GENERAL OPERATIONS
	BONE CYST, in	jection into or aspiration of (Anaes.)
47900	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60
	EPICONDYLIT	IS, open operation for (Anaes.)
47903	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45
	DIGITAL NAIL	OF TOE, removal of, not being a service to which item 47906 applies (Anaes.)
47904	Fee: \$58.25	Benefit: 75% = \$43.70 85% = \$49.55
	DIGITAL NAIL	OF TOE, removal of, in the operating theatre of a hospital (Anaes.)
47906	Fee: \$116.35	Benefit: 75% = \$87.30
	PULP SPACE IN	NFECTION, PARONYCHIA of FOOT, incision for, not being a service to which his Group applies (excluding aftercare) (Anaes.)
47912	(See para TN.8.4 o Fee: \$58.25	f explanatory notes to this Category) Benefit: 75% = \$43.70 85% = \$49.55
	INGROWING N portion of the nai	AIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and il bed (Anaes.)
47915	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60
		AIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, user, sodium hydroxide or acid but not including excision of nail bed (Anaes.)
47916	Fee: \$87.80	Benefit: 75% = \$65.85 85% = \$74.65
	INGROWING T	OENAIL, radical excision of nailbed (Anaes.)
47918	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45
	BONE GROWT	H STIMULATOR, insertion of (Anaes.) (Assist.)
47920	Fee: \$392.70	Benefit: 75% = \$294.55
		C PIN OR WIRE, insertion of, as an independent procedure (Anaes.)
47921	Fee: \$116.35	Benefit: 75% = \$87.30 85% = \$98.90
	BURIED WIRE,	PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, ring incision and suture, not being a service to which item 47927 or 47930 applies - per
47924	Fee: \$38.80	Benefit: 75% = \$29.10 85% = \$33.00
47927		PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes,

T8. SUF	RGICAL OPERATION	DNS	15. ORTHOPAEDIC
	removal of, in the	operating theatre of a hospital - per bone (Anaes.)	
	Fee: \$145.65	Benefit: 75% = \$109.25	
	were inserted for i	NAIL AND ASSOCIATED WIRES, PINS OR SCRInternal fixation purposes, <u>removal of</u> , not being a serv or 47927 applies - per bone (Anaes.) (Assist.)	
47930	Fee: \$271.80	Benefit: 75% = \$203.85	
		OSIS (NOT MORE THAN 20MM OF GROWTH ABO bunion and any associated bursa, not being a service a Anaes.)	
47933	(See para TN.8.112 Fee: \$213.45	of explanatory notes to this Category) Benefit: 75% = \$160.10 85% = \$181.45	
	LARGE EXOSTO (Assist.)	SSIS (GREATER THAN 20MM GROWTH ABOVE	BONE), excision of (Anaes.)
47936	(See para TN.8.112 Fee: \$262.10	of explanatory notes to this Category) Benefit: 75% = \$196.60	
	EXTERNAL FIX	ATION, removal of, in the operating theatre of a hosp	ital (Anaes.)
47948	Fee: \$165.05	Benefit: 75% = \$123.80	
	EXTERNAL FIXA	ATION, removal of, in conjunction with operations in anaes.)	volving internal fixation or bone
47951	Fee: \$194.05	Benefit: 75% = \$145.55 85% = \$164.95	
	TENDON, repair	of, as an independent procedure (Anaes.) (Assist.)	
47954	Fee: \$388.30	Benefit: 75% = \$291.25 85% = \$330.10	
	TENDON, large, l	engthening of, as an independent procedure (Anaes.)	(Assist.)
47957	Fee: \$291.15	Benefit: 75% = \$218.40	
	TENOTOMY, SU (Anaes.)	BCUTANEOUS, not being a service to which anothe	r item in this Group applies
47960	Fee: \$135.95	Benefit: 75% = \$102.00 85% = \$115.60	
	TENOTOMY, OP Group applies (An	EN, with or without tenoplasty, not being a service to aes.)	which another item in this
47963	Fee: \$223.25	Benefit: 75% = \$167.45 85% = \$189.80	
	TENDON OR LIC	GAMENT, TRANSFER, as an independent procedure	(Anaes.) (Assist.)
47966	Fee: \$446.50	Benefit: 75% = \$334.90	
	TENOSYNOVEC (Assist.)	TOMY, not being a service to which another item in t	this Group applies (Anaes.)
47969	Fee: \$271.80	Benefit: 75% = \$203.85	
	TENDON SHEAT Group applies (An	TH, open operation for teno-vaginitis, not being a servaes.)	ice to which another item in this
	Fee: \$217.15	Benefit: 75% = \$162.90	

RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	CALF, decompression fasciotomy of, for acute compartment syndrome, requiring
excision of musc	le and deep tissue (Anaes.) (Assist.)
Fee: \$380.70	Benefit: 75% = \$285.55
	CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring le and deep tissue (Anaes.)
Fee: \$231.20	Benefit: 75% = \$173.40
	LF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of the to which another item applies (Anaes.)
Fee: \$155.25	Benefit: 75% = \$116.45 85% = \$132.00
FORAGE (Drill	decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.)
Fee: \$376.30	Benefit: 75% = \$282.25
	BONE GRAFTS
FEMUR, bone g	raft to (Anaes.) (Assist.)
Fee: \$776.80	Benefit: 75% = \$582.60
FEMUR, bone g	raft to, with internal fixation (Anaes.) (Assist.)
Fee: \$941.75	Benefit: 75% = \$706.35
TIBIA, bone gra	ft to (Anaes.) (Assist.)
Fee: \$583.10	Benefit: 75% = \$437.35
TIBIA, bone gra	ft to, with internal fixation (Anaes.) (Assist.)
Fee: \$747.60	Benefit: 75% = \$560.70
	the graft to (Anaes.) (Assist.)
Fee: \$583.10	Benefit: 75% = \$437.35
-	the graft to, with internal fixation (Anaes.) (Assist.)
-	Benefit: 75% = \$560.70 JLNA, bone graft to (Anaes.) (Assist.)
	Benefit: 75% = \$437.35
RADIUS AND U	JLNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)
Fee: \$776.80	Benefit: 75% = \$582.60
RADIUS OR ULNA, bone graft to (Anaes.) (Assist.)	
Fee: \$388.30	Benefit: 75% = \$291.25
RADIUS OR UI	NA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.)
Fee: \$504.85	Benefit: 75% = \$378.65
	ne graft to, for non-union (Anaes.) (Assist.)
Fee: \$437.00	Benefit: 75% = \$327.75
	excision of musc Fee: \$380.70 FOREARM OR excision of musc Fee: \$231.20 FOREARM, CA not being a service Fee: \$155.25 FORAGE (Drill or Fee: \$376.30 FEMUR, bone graff Fee: \$941.75 TIBIA, bone graff Fee: \$583.10 TIBIA, bone graff Fee: \$747.60 HUMERUS, bone Fee: \$583.10 HUMERUS, bone Fee: \$747.60 RADIUS AND UNITED TO THE

GICAL OPERATION	ONS 15. ORTHOPAEDIC
SCAPHOID, bone	e graft to, for non-union, with internal fixation (Anaes.) (Assist.)
Fee: \$631.05	Benefit: 75% = \$473.30
SCAPHOID, bone (Assist.)	e graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.)
Fee: \$825.20	Benefit: 75% = \$618.90
BONE GRAFT, n	ot being a service to which another item in this Group applies (Anaes.) (Assist.)
Fee: \$456.30	Benefit: 75% = \$342.25
BONE GRAFT, w (Anaes.) (Assist.)	vith internal fixation, not being a service to which another item in this Group applies
Fee: \$631.05	Benefit: 75% = \$473.30
	OSTEOTOMY AND OSTEECTOMY
	ATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy ices to which item 49848 or 49851 applies, any of items 49848, 49851, 47933 or es.) (Assist.)
Fee: \$339.85	Benefit: 75% = \$254.90
	IETATARSAL, osteotomy or osteectomy of, with internal fixation, and excluding items 47933 or 47936 apply (Anaes.) (Assist.)
Fee: \$534.00	Benefit: 75% = \$400.50
	S, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR my or osteectomy of, excluding services to which items 47933 or 47936 apply
Fee: \$339.85	Benefit: 75% = \$254.90
CARPUS, osteoto	S, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR my or osteectomy of, with internal fixation, and excluding services to which items oply (Anaes.) (Assist.)
Fee: \$534.00	Benefit: 75% = \$400.50
HUMERUS, osteo (Anaes.) (Assist.)	otomy or osteectomy of, excluding services to which items 47933 or 47936 apply
Fee: \$650.35	Benefit: 75% = \$487.80
HUMERUS, osteotomy or osteectomy of, with internal fixation, and excluding services to which items 47933 or 47936 apply (Anaes.) (Assist.)	
Fee: \$825.20	Benefit: 75% = \$618.90
TIBIA, osteotomy (Assist.)	or osteectomy of, excluding services to which items 47933 or 47936 apply (Anaes.)
Fee: \$650.35	Benefit: 75% = \$487.80
TIBIA, osteotomy or 47936 apply (A	or osteectomy of, with internal fixation, and excluding services to which items 47933 naes.) (Assist.)
Fee: \$825.20	Benefit: 75% = \$618.90
	SCAPHOID, bone (Assist.) Fee: \$631.05 SCAPHOID, bone (Assist.) Fee: \$825.20 BONE GRAFT, note (Anaes.) (Assist.) Fee: \$631.05 PHALANX, MET of, excluding serve (Argandary (

T8. SUF	RGICAL OPERAT	IONS	15. ORTHOPAEDIC
			her than a service associated with surgery for a 47933 or 47936 applies (H) (Anaes.) (Assist.)
48424	(See para TN.8.12 Fee: \$776.80	7 of explanatory notes to this Categ Benefit: 75% = \$582.60	ory)
		LVIS, osteotomy or osteectomy 33 or 47936 apply (Anaes.) (Ass	of, with internal fixation, and excluding services to sist.)
48427	Fee: \$941.75	Benefit: 75% = \$706.35	
		EPIP	HYSEODESIS
	FEMUR, epiphy	siodesis of (Anaes.) (Assist.)	
48500	Fee: \$339.85	Benefit: 75% = \$254.90	
	TIBIA AND FIE	ULA, epiphysiodesis of (Anaes	s.) (Assist.)
48503	Fee: \$339.85	Benefit: 75% = \$254.90	
	- 	AND FIBULA, epiphysiodesis	of (Anaes.) (Assist.)
48506	Fee: \$504.85	Benefit: 75% = \$378.65	
10300		SIS, staple arrest of hemiepiphys	sis (Anaes.)
48509			` ,
46309	Fee: \$242.85	Benefit: 75% = \$182.15 SIS, operation to prevent closure	of plate (Anges) (Assist)
		-	5 of plate (7 maes.) (7 issist.)
48512	Fee: \$922.35	Benefit: 75% = \$691.80	IOH DED
	CHOIH DED		HOULDER
	(Anaes.) (Assist.		ent or removal of calcium deposit from cuff or both
48900	Fee: \$291.15	Benefit: 75% = \$218.40 85	% = \$247.50
		compression of subacromial spatial clavicle, or any combination	ace by acromioplasty, excision of coraco-acromial (Anaes.) (Assist.)
48903	Fee: \$582.50	Benefit: 75% = \$436.90	
		from cuff, or both - not being a s	cision of coraco-acromial ligament or removal of service associated with a service to which item 48900
48906	Fee: \$582.50	Benefit: 75% = \$436.90	
	excision of corac		ecompression of subacromial space by acromioplasty, clavicle, or any combination, not being a service oplies (Anaes.) (Assist.)
48909	Fee: \$776.80	Benefit: 75% = \$582.60	
	SHOULDER, ar	chrotomy of (Anaes.) (Assist.)	
48912	Fee: \$339.85	Benefit: 75% = \$254.90 85	% = \$288.90
	+	mi-arthroplasty of (Anaes.) (As	
48915	Fee: \$776.80	Benefit: 75% = \$582.60	
TU/1J	Ε ε ε φ//0.60	Delicit. 1370 – \$362.00	

T8. SUF	RGICAL OPERATION	DNS 15. ORTHOPAEDIC
	SHOULDER, tota (Assist.)	l replacement arthroplasty of, including any associated rotator cuff repair (Anaes.)
48918	Fee: \$1,553.50	Benefit: 75% = \$1165.15
	SHOULDER, tota	l replacement arthroplasty, revision of (Anaes.) (Assist.)
48921	Fee: \$1,601.90	Benefit: 75% = \$1201.45
	SHOULDER, total both (Anaes.) (As	l replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or sist.)
48924	Fee: \$1,844.70	Benefit: 75% = \$1383.55
	SHOULDER pros	thesis, removal of (Anaes.) (Assist.)
48927	Fee: \$378.50	Benefit: 75% = \$283.90
	SHOULDER, stal	ilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.)
48930	Fee: \$776.80	Benefit: 75% = \$582.60
		illisation procedure for multi-directional instability, including anterior or posterior (or performed (Anaes.) (Assist.)
48933	Fee: \$1,019.40	Benefit: 75% = \$764.55
	SHOULDER, syn	ovectomy of, as an independent procedure (Anaes.) (Assist.)
48936	Fee: \$776.80	Benefit: 75% = \$582.60
	SHOULDER, artl	rodesis of, with synovectomy if performed (Anaes.) (Assist.)
48939	Fee: \$1,116.50	Benefit: 75% = \$837.40
	SHOULDER, artl	rodesis of, with synovectomy if performed, with removal of prosthesis, requiring bone l fixation (Anaes.) (Assist.)
48942	Fee: \$1,456.30	Benefit: 75% = \$1092.25
		gnostic arthroscopy of (including biopsy) - not being a service associated with any procedure of the shoulder region (Anaes.) (Assist.)
48945	Fee: \$281.45	Benefit: 75% = \$211.10
	decompression of	roscopic surgery of, involving any 1 or more of: removal of loose bodies; calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - associated with any other arthroscopic procedure of the shoulder region (Anaes.)
48948	Fee: \$631.05	Benefit: 75% = \$473.30
		roscopic division of coraco-acromial ligament including acromioplasty - not being a with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.)
48951	Fee: \$922.35	Benefit: 75% = \$691.80
		roscopic total synovectomy of, including release of contracture when performed - not occiated with any other arthroscopic procedure of the shoulder region (Anaes.)
48954	Fee: \$970.85	Benefit: 75% = \$728.15
48957	SHOULDER, arth	roscopic stabilisation of, for recurrent instability including labral repair or

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC
		n performed - not being a service associated with any other arthroscopic procedure of n (Anaes.) (Assist.)
	Fee: \$1,116.50	Benefit: 75% = \$837.40
	assisted or mini o	onstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic pen means; arthroscopic acromioplasty; or resection of acromioclavicular joint by when performed - not being a service associated with any other procedure of the Anaes.) (Assist.)
48960	Fee: \$970.85	Benefit: 75% = \$728.15
		ELBOW
	ELBOW, arthroto (Anaes.) (Assist.)	my of, involving 1 or more of lavage, removal of loose body or division of contracture
49100	Fee: \$339.85	Benefit: 75% = \$254.90
	ELBOW, ligamen	tous stabilisation of (Anaes.) (Assist.)
49103	Fee: \$728.10	Benefit: 75% = \$546.10
	ELBOW, arthrod	esis of, with synovectomy if performed (Anaes.) (Assist.)
49106	Fee: \$970.85	Benefit: 75% = \$728.15 85% = \$886.15
	ELBOW, total sy	novectomy of (Anaes.) (Assist.)
49109	Fee: \$728.10	Benefit: 75% = \$546.10
	ELBOW, silastic	or other replacement of radial head (Anaes.) (Assist.)
49112	Fee: \$728.10	Benefit: 75% = \$546.10
	ELBOW, total jo	nt replacement of (Anaes.) (Assist.)
49115	Fee: \$1,164.90	Benefit: 75% = \$873.70
	ELBOW, total re (Assist.)	placement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49116	Fee: \$1,537.70	Benefit: 75% = \$1153.30
		placement arthroplasty of, revision procedure, requiring bone grafting, including esis (Anaes.) (Assist.)
49117	Fee: \$1,845.25	Benefit: 75% = \$1383.95
		tic arthroscopy of, including biopsy and lavage, not being a service associated with any procedure of the elbow (Anaes.) (Assist.)
49118	Fee: \$281.45	Benefit: 75% = \$211.10
	release of contrac	opic surgery involving any 1 or more of: drilling of defect, removal of loose body; ture or adhesions; chondroplasty; or osteoplasty - not being a service associated with opic procedure of the elbow (Anaes.) (Assist.)
49121	Fee: \$631.05	Benefit: 75% = \$473.30
		WRIST
49200	WRIST, arthrode	sis of, with synovectomy if performed, with or without bone graft and internal fixation

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	of the radiocarpal joint (Anaes.) (Assist.)	
	(See para TN.8.116 of explanatory notes to this Category Fee: \$844.55 Benefit: 75% = \$633.45	y)
	WRIST, limited arthrodesis of the intercarpal joint bone graft (Anaes.) (Assist.)	with synovectomy if performed, with or without
49203	(See para TN.8.116 of explanatory notes to this Category Fee: \$631.05 Benefit: 75% = \$473.30	<i>(</i>)
	WRIST, proximal carpectomy of, including styloid	ectomy when performed (Anaes.) (Assist.)
49206	(See para TN.8.116 of explanatory notes to this Category Fee: \$582.50 Benefit: 75% = \$436.90	<i>(</i>)
	WRIST, total replacement arthroplasty of (Anaes.)	(Assist.)
49209	(See para TN.8.116 of explanatory notes to this Category Fee: \$776.80 Benefit: 75% = \$582.60	7)
	WRIST, total replacement arthroplasty of, revision (Assist.)	procedure, including removal of prosthesis (Anaes.)
49210	Fee: \$1,025.35 Benefit: 75% = \$769.05	
	WRIST, total replacement arthroplasty of, revision removal of prosthesis (Anaes.) (Assist.)	procedure, requiring bone grafting, including
49211	Fee: \$1,230.45 Benefit: 75% = \$922.85	
	WRIST, arthrotomy of (Anaes.)	
49212	(See para TN.8.116 of explanatory notes to this Category Fee: \$242.85 Benefit: 75% = \$182.15	<i>(</i>)
	WRIST, reconstruction of, including repair of single associated arthrotomy (Anaes.) (Assist.)	le or multiple ligaments or capsules, including
49215	(See para TN.8.116 of explanatory notes to this Category Fee: \$670.00 Benefit: 75% = \$502.50	<i>(</i>)
	WRIST, diagnostic arthroscopy of, including radio - not being a service associated with any other arth (Assist.)	carpal or midcarpal joints, or both (including biopsy) roscopic procedure of the wrist joint (Anaes.)
49218	(See para TN.8.116 of explanatory notes to this Category Fee: \$281.45 Benefit: 75% = \$211.10	7)
	WRIST, arthroscopic surgery of, involving any 1 or release of adhesions; local synovectomy; or debrid with any other arthroscopic procedure of the wrist j	
49221	(See para TN.8.116 of explanatory notes to this Category Fee: \$631.05 Benefit: 75% = \$473.30	<i>(</i>)
	-	tinct areas; or osteoplasty including excision of the ce associated with any other arthroscopic procedure of
49224	(See para TN.8.116 of explanatory notes to this Category Fee: \$728.10 Benefit: 75% = \$546.10	<i>(</i>)

T8. SUF	GICAL OPERATION	ONS	15. ORTHOPAEDIC
			or stabilisation procedure for ligamentous arthroscopic procedure of the wrist joint
	(See para TN.8.116	of explanatory notes to this Category)	
49227	Fee: \$728.10	Benefit: 75% = \$546.10	
		HIP	
	SACROILIAC JO	INT arthrodesis of (Anaes.) (Assist.)	
49300	Fee: \$537.55	Benefit: 75% = \$403.20	
		f, including lavage, drainage or biopsy rgery for femoroacetabular impingeme	
49303	(See para TN.8.127 Fee: \$563.05	of explanatory notes to this Category) Benefit: 75% = \$422.30	
	HIP arthrodesis o	f, with synovectomy if performed (Ana	nes.) (Assist.)
49306	Fee: \$1,116.50	Benefit: 75% = \$837.40	
	HIP, arthrectomy (non cement)) (A		emoval of prosthesis (Austin Moore or similar
49309	Fee: \$776.80	Benefit: 75% = \$582.60	
	HIP, arthrectomy or similar) (Anaes		emoval of prosthesis (cemented, porous coated
49312	Fee: \$970.85	Benefit: 75% = \$728.15	
	HIP, arthroplasty	of, unipolar or bipolar (Anaes.) (Assist.	.)
49315	Fee: \$873.80	Benefit: 75% = \$655.35	
.,		nent arthroplasty of, including minor be	one grafting (Anaes.) (Assist.)
49318	Fee: \$1,359.00	Benefit: 75% = \$1019.25	
49316			ed minor grafting, if performed - bilateral
49319	Fee: \$2,387.65	Benefit: 75% = \$1790.75	
	HIP, total replacer (Anaes.) (Assist.)	nent arthroplasty of, including major be	one grafting, including obtaining of graft
49321	Fee: \$1,650.65	Benefit: 75% = \$1238.00	
	HIP, total replacer (Assist.)	ment arthroplasty of, revision procedure	e including removal of prosthesis (Anaes.)
49324	Fee: \$1,941.80	Benefit: 75% = \$1456.35	
		ment arthroplasty of, revision procedure g of graft (Anaes.) (Assist.)	e requiring bone grafting to acetabulum,
49327	Fee: \$2,233.00	Benefit: 75% = \$1674.75	
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.)		

T8. SUF	RGICAL OPERATION	ONS 15. ORTH	HOPAEDIC	
	Fee: \$2,233.00	Benefit: 75% = \$1674.75		
		ment arthroplasty of, revision procedure requiring bone grafting to both ace ling obtaining of graft (Anaes.) (Assist.)	tabulum	
49333	Fee: \$2,524.30	Benefit: 75% = \$1893.25		
	treatment of the fi	a fracture of the femur where revision total hip replacement is required as practure (not including intra-operative fracture), being a service associated w 324 to 49333 apply (Anaes.) (Assist.)		
49336	Fee: \$368.85	Benefit: 75% = \$276.65		
	HIP, revision tota cm in length (Ana	ll replacement of, requiring anatomic specific allograft of proximal femur graes.) (Assist.)	reater than 5	
49339	Fee: \$2,864.10	Benefit: 75% = \$2148.10		
	HIP, revision tota	l replacement of, requiring anatomic specific allograft of acetabulum (Anae	es.) (Assist.)	
49342	Fee: \$2,864.10	Benefit: 75% = \$2148.10		
	HIP, revision tota (Anaes.) (Assist.)	l replacement of, requiring anatomic specific allograft of both femur and ac	etabulum	
49345	Fee: \$3,398.00	Benefit: 75% = \$2548.50		
	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.)			
49346	Fee: \$873.80	Benefit: 75% = \$655.35		
	HIP, diagnostic at the hip (Anaes.) (rthroscopy of, not being a service associated with any other arthroscopic pro Assist.)	ocedure of	
49360	Fee: \$354.70	Benefit: 75% = \$266.05		
		rthroscopy of, with synovial biopsy, not being a service associated with any edure of the hip (Anaes.) (Assist.)	other	
49363	Fee: \$427.15	Benefit: 75% = \$320.40 85% = \$363.10		
		surgery of, other than a service associated with another arthroscopic processociated with surgery for femoroacetabular impingement (H) (Anaes.) (A		
49366	(See para TN.8.127 Fee: \$631.05	of explanatory notes to this Category) Benefit: 75% = \$473.30		
	KNEE			
		y of, involving 1 or more of; capsular release, biopsy or lavage, or removal ody (Anaes.) (Assist.)	of loose	
49500	Fee: \$388.30	Benefit: 75% = \$291.25		
	chondroplasty of,	total meniscectomy of, repair of collateral or cruciate ligament, patellectom osteoplasty of, patellofemoral stabilisation or single transfer of ligament or which another item in this Group applies) - any 1 procedure (Anaes.) (Assi	r tendon (not	
49503	Fee: \$504.85	Benefit: 75% = \$378.65		
49506		total meniscectomy of, repair of collateral or cruciate ligament, patellectom osteoplasty of, patellofemoral stabilisation or single transfer of ligament or		

T8. SUF	RGICAL OPERATION	ONS 15. ORTHOPAEDIC
	being a service to (Assist.)	which another item in this Group applies) - any 2 or more procedures (Anaes.)
	Fee: \$757.35	Benefit: 75% = \$568.05
	KNEE, total syno	vectomy or arthrodesis with synovectomy if performed (Anaes.) (Assist.)
49509	Fee: \$776.80	Benefit: 75% = \$582.60
	KNEE, arthrodesi	s of, with synovectomy if performed, with removal of prosthesis (Anaes.) (Assist.)
49512	Fee: \$1,116.50	Benefit: 75% = \$837.40
		f prosthesis, cemented or uncemented, including associated cement, as the first stage dure (Anaes.) (Assist.)
49515	Fee: \$873.80	Benefit: 75% = \$655.35
	KNEE, hemiarthro	oplasty of (Anaes.) (Assist.)
49517	Fee: \$1,244.05	Benefit: 75% = \$933.05
	KNEE, total repla	cement arthroplasty of (Anaes.) (Assist.)
49518	Fee: \$1,359.00	Benefit: 75% = \$1019.25
	KNEE, total repla (Anaes.) (Assist.)	cement arthroplasty of, including associated minor grafting, if performed - bilateral
49519	Fee: \$2,387.65	Benefit: 75% = \$1790.75
		cement arthroplasty of, requiring major bone grafting to femur or tibia, including (Anaes.) (Assist.)
49521	Fee: \$1,650.65	Benefit: 75% = \$1238.00
	KNEE, total repla obtaining of graft	cement arthroplasty of, requiring major bone grafting to femur and tibia, including (Anaes.) (Assist.)
49524	Fee: \$1,941.80	Benefit: 75% = \$1456.35
	KNEE, total repla (Assist.)	cement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.)
49527	Fee: \$1,650.65	Benefit: 75% = \$1238.00
		cement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, g of graft and including removal of prosthesis (Anaes.) (Assist.)
49530	Fee: \$2,039.00	Benefit: 75% = \$1529.25
		cement arthroplasty of, revision procedure, requiring bone grafting to both femur and training of graft and including removal of prosthesis (Anaes.) (Assist.)
49533	Fee: \$2,330.25	Benefit: 75% = \$1747.70
	KNEE, patello-fer	moral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.)
49534	Fee: \$463.60	Benefit: 75% = \$347.70
49536	cruciate or collate	econstruction of, for chronic instability (open or arthroscopic, or both) involving either ral ligaments, including notchplasty when performed, not being a service associated hroscopic procedure of the knee (Anaes.) (Assist.)

T8. SUR	GICAL OPERAT	IONS	15. ORTHOPAEDIC	
	Fee: \$970.85	Benefit: 75% = \$728.15		
	including notchp	active surgery of cruciate ligament or ligaments (lasty when performed and surgery to other internet in this Group applies or a service associated ves.) (Assist.)	nal derangements, not being a service to	
49539	Fee: \$970.85	Benefit: 75% = \$728.15		
	including notchp	active surgery to cruciate ligament or ligaments (lasty, meniscus repair, extracapsular procedure a ssociated with any other arthroscopic procedure	and debridement when performed, not	
49542	Fee: \$1,359.00	Benefit: 75% = \$1019.25		
	KNEE, revision	arthrodesis of, with synovectomy if performed (A	Anaes.) (Assist.)	
49545	Fee: \$776.80	Benefit: 75% = \$582.60		
	KNEE, revision	of patello-femoral stabilisation (Anaes.) (Assist.))	
49548	Fee: \$970.85	Benefit: 75% = \$728.15		
	KNEE, revision	of procedures to which item 49536, 49539 or 493	542 applies (Anaes.) (Assist.)	
49551	Fee: \$1,359.00	Benefit: 75% = \$1019.25		
	KNEE, revision (Assist.)	of total replacement of, by anatomic specific allo	ograft of tibia or femur (Anaes.)	
49554	Fee: \$1,941.80	Benefit: 75% = \$1456.35		
	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with autologous chondrocyte implantation or matrix-induced autologous chondrocyte implantation or any other arthroscopic procedure of the knee region (Anaes.) (Assist.)			
49557	(See para TN.8.11 Fee: \$281.45	7 of explanatory notes to this Category) Benefit: 75% = \$211.10		
		ppic surgery of, involving 1 or more of: debriden ny other arthroscopic procedure of the knee regi		
49558	Fee: \$281.45	Benefit: 75% = \$211.10		
	similar) implant;	opic surgery of, involving chondroplasty requiring including any associated debridement or oestopic dedure of the knee region (Anaes.) (Assist.)		
49559	Fee: \$421.50	Benefit: 75% = \$316.15		
	KNEE, arthroscopic surgery of, involving 1 or more of: partial or total meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.)			
49560	Fee: \$568.85	Benefit: 75% = \$426.65		
	removal of loose	OSCOPIC SURGERY OF, involving 1 or more obody or lateral release; where the procedure incondroplasty - not associated with any other arthroperature.	ludes associated debridement,	
49561	Fee: \$695.05	Benefit: 75% = \$521.30		
49561			reserve procedure of the know reg	

T8. SUR	RGICAL OPERATI	ONS	15. ORTHOPAEDIC
	removal of loose drilling or carbon		re includes chondroplasty requiring multiple lebridement or osteoplasty - not associated
49562	Fee: \$758.45	Benefit: 75% = \$568.85	
	chondral graft (ex	pic surgery of, involving 1 or more of: meacluding autologous chondrocyte implantal antation) -not associated with any other ar	tion or matrix-induced autologous
49563	(See para TN.8.117 Fee: \$821.60	of explanatory notes to this Category) Benefit: 75% = \$616.20	
	release, medial ca	moral stabilisation of, combined arthrosco apsulorrhaphy and tendon transfer, not bein edure of the knee (Anaes.) (Assist.)	
49564	Fee: \$947.75	Benefit: 75% = \$710.85	
		pic total synovectomy of, not being a servi knee (Anaes.) (Assist.)	ce associated with any other arthroscopic
49566	Fee: \$776.80	Benefit: 75% = \$582.60	
	KNEE, mobilisat (Anaes.) (Assist.)	- · · · · · · · · · · · · · · · · · · ·	e muscle or tendon release (quadricepsplasty)
49569	Fee: \$776.80	Benefit: 75% = \$582.60	
		ANKLE	
	ANKLE, diagnos	tic arthroscopy of, including biopsy (Anae	s.) (Assist.)
49700	Fee: \$281.45	Benefit: 75% = \$211.10	
	ANKLE, arthroso of the ankle (Ana		ated with any other arthroscopic procedure
49703	Fee: \$631.05	Benefit: 75% = \$473.30	
	ANKLE, arthroto (Anaes.) (Assist.)	·	noval of loose body or division of contracture
49706	Fee: \$339.85	Benefit: 75% = \$254.90	
	ANKLE, ligamer	tous stabilisation of (Anaes.) (Assist.)	
49709	Fee: \$728.10	Benefit: 75% = \$546.10	
		esis of, with synovectomy if performed (A	naes.) (Assist.)
49712	Fee: \$776.80	Benefit: 75% = \$582.60	
- · • •	+	nt replacement of (Anaes.) (Assist.)	
49715	Fee: \$1,164.90	Benefit: 75% = \$873.70	
.,,13	1		are, including removal of prosthesis (Anaes.)
	(Assist.)		

T8. SUR	RGICAL OPERATION	ONS 15. ORTHOPAEDI
	_	lacement arthroplasty of, revision procedure, requiring bone grafting, including esis (Anaes.) (Assist.)
49717	Fee: \$1,845.25	Benefit: 75% = \$1383.95
	ANKLE, Achilles	tendon or other major tendon, repair of (Anaes.) (Assist.)
49718	Fee: \$388.30	Benefit: 75% = \$291.25
	ANKLE, Achilles	tendon rupture managed by non-operative treatment
49721	Fee: \$242.85	Benefit: 75% = \$182.15 85% = \$206.45
	ANKLE, Achilles	tendon, secondary repair or reconstruction of (Anaes.) (Assist.)
49724	Fee: \$679.75	Benefit: 75% = \$509.85
	ANKLE, Achilles	tendon, operation for lengthening (Anaes.) (Assist.)
49727	Fee: \$291.15	Benefit: 75% = \$218.40
		ing of the gastrocnemius aponeurosis and soleus fascia, for the correction of equinus ren with cerebral palsy (Anaes.) (Assist.)
49728	Fee: \$582.35	Benefit: 75% = \$436.80
		FOOT
	FOOT, flexor or e	xtensor tendon, primary repair of (Anaes.)
49800	Fee: \$135.95	Benefit: 75% = \$102.00 85% = \$115.60
	FOOT, flexor or 6	xtensor tendon, secondary repair of (Anaes.)
49803	Fee: \$174.80	Benefit: 75% = \$131.10 85% = \$148.60
	FOOT, subcutane	ous tenotomy of, 1 or more tendons (Anaes.)
49806	Fee: \$135.95	Benefit: 75% = \$102.00 85% = \$115.60
	FOOT, open teno	omy of, with or without tenoplasty (Anaes.)
49809	Fee: \$223.25	Benefit: 75% = \$167.45
	FOOT, tendon or applies (Anaes.) (ligament transplantation of, not being a service to which another item in this Group Assist.)
49812	Fee: \$446.50	Benefit: 75% = \$334.90
	FOOT, triple arth	rodesis of, with synovectomy if performed (Anaes.) (Assist.)
49815	Fee: \$776.80	Benefit: 75% = \$582.60
	FOOT, excision of	f calcaneal spur (Anaes.) (Assist.)
49818	Fee: \$281.45	Benefit: 75% = \$211.10
	· ·	of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar teral (Anaes.) (Assist.)
49821	Fee: \$446.50	Benefit: 75% = \$334.90
49824		of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar eral (Anaes.) (Assist.)

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC		
	Fee: \$781.65	Benefit: 75% = \$586.25		
	FOOT, correction	n of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.)		
49827	Fee: \$485.40	Benefit: 75% = \$364.05		
	FOOT, correction	n of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.)		
49830	Fee: \$849.50	Benefit: 75% = \$637.15		
		n of hallux valgus by osteotomy of first metatarsal with or without internal fixation and excision of exostoses associated with the first metatarsophalangeal joint - unilateral		
49833	Fee: \$534.00	Benefit: 75% = \$400.50		
		n of hallux valgus by osteotomy of first metatarsal with or without internal fixation and excision of exostoses associated with the first metatarsophalangeal joint - bilateral		
49836	Fee: \$922.35	Benefit: 75% = \$691.80		
	tendon, with or v	n of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus vithout internal fixation and with or without excision of exostoses associated with the alangeal joint - unilateral (Anaes.) (Assist.)		
49837	Fee: \$667.45	Benefit: 75% = \$500.60		
	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.)			
49838	Fee: \$1,152.70	Benefit: 75% = \$864.55		
	FOOT, correction (Assist.)	n of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.)		
49839	Fee: \$534.00	Benefit: 75% = \$400.50		
	FOOT, correction (Assist.)	n of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.)		
49842	Fee: \$922.35	Benefit: 75% = \$691.80		
	FOOT, arthrodes	sis of, first metatarso-phalangeal joint, with synovectomy if performed (Anaes.) (Assist.)		
49845	Fee: \$485.40	Benefit: 75% = \$364.05		
	FOOT, correction	n of claw or hammer toe (Anaes.)		
49848	Fee: \$165.05	Benefit: 75% = \$123.80 85% = \$140.30		
	FOOT, correction	n of claw or hammer toe with internal fixation (Anaes.)		
49851	Fee: \$213.45	Benefit: 75% = \$160.10		
		lantar fasciotomy or fasciectomy of (Anaes.) (Assist.)		
49854	Fee: \$388.30	Benefit: 75% = \$291.25		
		o-phalangeal joint replacement (Anaes.) (Assist.)		
49857	Fee: \$359.20	Benefit: 75% = \$269.40		

GICAL OPERAT	IONS 15. ORTHOPAEDIC
FOOT, synovect	omy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.)
Fee: \$291.15	Benefit: 75% = \$218.40
FOOT, synovect	omy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.)
Fee: \$437.00	Benefit: 75% = \$327.75
FOOT, neurecto	my for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.)
Fee: \$310.45	Benefit: 75% = \$232.85
-	NOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or ach attendance (Anaes.)
Fee: \$58.25	Benefit: 75% = \$43.70 85% = \$49.55
	OTHER JOINTS
	ic arthroscopy of (including biopsy), not being a service to which another item in this ad not being a service associated with any other arthroscopic procedure (Anaes.)
Fee: \$281.45	Benefit: 75% = \$211.10 85% = \$239.25
JOINT, arthrosc (Assist.)	opic surgery of, not being a service to which another item in this Group applies (Anaes.)
Fee: \$631.05	Benefit: 75% = \$473.30
JOINT, arthroto	my of, not being a service to which another item in this Group applies (Anaes.) (Assist.)
Fee: \$339.85	Benefit: 75% = \$254.90
JOINT, synovec (Assist.)	tomy of, not being a service to which another item in this Group applies (Anaes.)
Fee: \$322.05	Benefit: 75% = \$241.55 85% = \$273.75
	tion of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, ce to which another item in this Group applies (Anaes.) (Assist.)
Fee: \$485.40	Benefit: 75% = \$364.05
	sis of, not being a service to which another item in this Group applies, with performed (Anaes.) (Assist.)
Fee: \$485.40	Benefit: 75% = \$364.05
tissues deeper th	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.)
Fee: \$372.35	Benefit: 75% = \$279.30
	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.)
Fee: \$147.45	Benefit: 75% = \$110.60
SUBTALAR JO	INT, arthrodesis of, with synovectomy if performed (Anaes.) (Assist.)
Fee: \$446.50	Benefit: 75% = \$334.90
	Fee: \$291.15 FOOT, synovect Fee: \$437.00 FOOT, neurector Fee: \$310.45 TALIPES EQUIT manipulation - ext Fee: \$58.25 JOINT, diagnost Group applies ar (Assist.) Fee: \$281.45 JOINT, arthrosco (Assist.) Fee: \$631.05 JOINT, arthrotor Fee: \$339.85 JOINT, synovect (Assist.) Fee: \$322.05 JOINT, stabilisate not being a servit being a servit fee: \$485.40 JOINT, arthrode synovectomy if pee: \$485.40 CICATRICIAL tissues deeper the applies (Anaes.) Fee: \$372.35 JOINT or JOINT associated with a fee: \$147.45 SUBTALAR JO

T8. SUF	RGICAL OPERAT	IONS 15. ORTHOPAEDIC
	GREATER TRO	CHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.)
50121	Fee: \$873.80	Benefit: 75% = \$655.35
		TS, arthroplasty of, by any technique not being a service to which another item applies
50127	Fee: \$724.45	Benefit: 75% = \$543.35
	JOINT OR JOIN (Assist.)	TS, application of external fixator to, other than for treatment of fractures (Anaes.)
50130	Fee: \$322.05	Benefit: 75% = \$241.55
		MALIGNANT DISEASE
		OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, cluding aftercare) (Anaes.)
50200	Fee: \$194.05	Benefit: 75% = \$145.55 85% = \$164.95
		OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, ascular structures, open biopsy of (not including aftercare) (Anaes.) (Assist.)
50201	Fee: \$339.75	Benefit: 75% = \$254.85
	BONE OR MAL (Assist.)	IGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.)
50203	Fee: \$427.20	Benefit: 75% = \$320.40 85% = \$363.15
		R, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, ft or cementation (Anaes.) (Assist.)
50206	Fee: \$631.05	Benefit: 75% = \$473.30
		R, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen ft, allograft or cementation (Anaes.) (Assist.)
50209	Fee: \$776.80	Benefit: 75% = \$582.60
		r AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.)
50212	Fee: \$1,699.00	Benefit: 75% = \$1274.25
	enbloc resection	r AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, of, with compartmental or wide excision of soft tissue, with intercalary reconstruction raft or autograft) (Anaes.) (Assist.)
50215	Fee: \$2,135.90	Benefit: 75% = \$1601.95
		TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of ith synovectomy if performed (Anaes.) (Assist.)
50218	Fee: \$2,815.60	Benefit: 75% = \$2111.70
		r AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SHOULDER, enbloc resection of (Anaes.) (Assist.)
	i	

T8. SUF	RGICAL OPERATIO	NS	15. ORTHOPAEDIC
		OULDER, enbloc resection of, with	OUR of PELVIS, SACRUM or SPINE; or reconstruction by prosthesis, allograft or
50224	Fee: \$2,912.60	Benefit: 75% = \$2184.45 85% = \$2	2827.90
		NE TUMOUR, enbloc resection of, vithout prosthetic replacement (Anae	with massive anatomic specific allograft or s.) (Assist.)
50227	Fee: \$3,398.00	Benefit: 75% = \$2548.50	
	BENIGN TUMOU (Anaes.) (Assist.)	R, resection of, requiring anatomic s	pecific allograft, with or without internal fixation
50230	Fee: \$1,747.55	Benefit: 75% = \$1310.70	
	MALIGNANT TU	MOUR, amputation for, hemipelvec	comy or interscapulo-thoracic (Anaes.) (Assist.)
50233	Fee: \$2,233.00	Benefit: 75% = \$1674.75	
	MALIGNANT TU femur (Anaes.) (As		ulation, shoulder disarticulation or proximal third
50236	Fee: \$1,747.55	Benefit: 75% = \$1310.70	
	MALIGNANT TU applies (Anaes.) (A		service to which another item in this Group
50239	Fee: \$1,164.90	Benefit: 75% = \$873.70	
		LIMB LENGTHENING AND DE	FORMITY CORRECTION
		ΓY, slow correction of, using ring fix ble only once in any 12 month period	cator or similar device, including all associated (Anaes.) (Assist.)
50300	Fee: \$1,193.85	Benefit: 75% = \$895.40	
		vice, in the operating theatre of a hos	ction, with application of an external fixator or pital - payable only once per limb in any 12
50303	Fee: \$1,630.00	Benefit: 75% = \$1222.50	
			olar, or bone transport is performed or where the v, or where the lengthening is greater than 5cm
50306	Fee: \$2,545.00	Benefit: 75% = \$1908.75 85% = \$2	2460.30
	fixation pins, perfo	· ·	of, with or without insertion or removal of e operating theatre of a hospital, not being a (Assist.)
50309	Fee: \$314.60	Benefit: 75% = \$235.95	
		omy of, by arthroscopic or open mea kle (Anaes.) (Assist.)	ns - not associated with any other arthroscopic
50312	Fee: \$721.95	Benefit: 75% = \$541.50	
	TALIPES EQUINO	OVARUS, posterior release of (Anae	s.) (Assist.)
50315	Fee: \$714.95	Benefit: 75% = \$536.25	
50515	1 00. φ/14.33	Delicit. 13/0 — \$330.23	

T8. SUF	RGICAL OPERATI	ONS 15. ORTHOPAEDIC		
	TALIPES EQUIN	OVARUS, medial release of (Anaes.) (Assist.)		
50318	Fee: \$714.95	Benefit: 75% = \$536.25		
30316		OVARUS, combined postero-medial release of (Anaes.) (Assist.)		
50321	Fee: \$957.85	Benefit: 75% = \$718.40		
	TALIPES EQUIT	OVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.)		
50324	Fee: \$1,365.55	Benefit: 75% = \$1024.20		
	TALIPES EQUIN	OVARUS, bilateral procedures (Anaes.) (Assist.)		
50327	Fee: \$1,665.60	Benefit: 75% = \$1249.20		
	plaster, performed	OVARUS, or talus, vertical congenital - post operative manipulation and change of under general anaesthesia in the operating theatre of a hospital, not being a service to , 50318, 50321, 50324 or 50327 applies (Anaes.)		
50330	Fee: \$235.85	Benefit: 75% = \$176.90		
	TARSAL COAL (Assist.)	TION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.)		
50333	Fee: \$636.10	Benefit: 75% = \$477.10		
	TALUS, VERTIO (Assist.)	AL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.)		
50336	Fee: \$950.85	Benefit: 75% = \$713.15		
	FOOT AND ANI (Assist.)	LE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.)		
50339	Fee: \$579.10	Benefit: 75% = \$434.35		
		LE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to or aspect of foot (Anaes.) (Assist.)		
50342	Fee: \$672.00	Benefit: 75% = \$504.00		
		ION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of and release of capsule contracture (Anaes.) (Assist.)		
50345	Fee: \$357.50	Benefit: 75% = \$268.15		
		HIP, KNEE AND LEG PROCEDURES		
	KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital (Anaes.)			
50348	Fee: \$235.85	Benefit: 75% = \$176.90		
	HIP, congenital d	slocation of, treatment of, by closed reduction (Anaes.)		
50349	Fee: \$330.15	Benefit: 75% = \$247.65 85% = \$280.65		
		al dislocation of, open reduction of (Anaes.) (Assist.)		
50351	Fee: \$1,647.15	Benefit: 75% = \$1235.40		
20221	rec. \$1,047.13	Denotite 1370 - \$1233.40		

T8. SUF	RGICAL OPERATION	NS 15. ORTHOPAEDIC
	HIP, congenital dattendance (Anaes	slocation of, treatment of, involving supervision of splint, harness or cast - each
50352	Fee: \$58.25	Benefit: 75% = \$43.70 85% = \$49.55
	HIP SPICA, initia (Assist.)	application of, for congenital dislocation of hip (excluding aftercare) (Anaes.)
50353	Fee: \$365.90	Benefit: 75% = \$274.45
	TIBIA, pseudarth	osis of, congenital, resection and internal fixation (Anaes.) (Assist.)
50354	Fee: \$1,351.05	Benefit: 75% = \$1013.30 85% = \$1266.35
	KNEE, LEG OR (Anaes.) (Assist.)	HIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer
50357	Fee: \$579.10	Benefit: 75% = \$434.35
	KNEE, LEG OR	HIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.)
50360	Fee: \$672.00	Benefit: 75% = \$504.00
	KNEE, contractur (Anaes.) (Assist.)	e of, posterior release involving multiple tendon lengthening or tenotomies, unilateral
50363	Fee: \$514.65	Benefit: 75% = \$386.00
	KNEE, contractur (Anaes.) (Assist.)	e of, posterior release involving multiple tendon lengthening or tenotomies, bilateral
50366	Fee: \$900.75	Benefit: 75% = \$675.60
		e of, posterior release involving multiple tendon lengthening with or without ease of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.)
50369	Fee: \$672.00	Benefit: 75% = \$504.00
		e of, posterior release involving multiple tendon lengthening with or without ease of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.)
50372	Fee: \$1,179.55	Benefit: 75% = \$884.70
		f, medial release, involving lengthening of, or division of the adductors and psoas with of the obturator nerve, unilateral (Anaes.) (Assist.)
50375	Fee: \$514.65	Benefit: 75% = \$386.00
		f, medial release, involving lengthening of, or division of the adductors and psoas with of the obturator nerve, bilateral (Anaes.) (Assist.)
50378	Fee: \$900.75	Benefit: 75% = \$675.60
		f, anterior release, involving lengthening of, or division of the hip flexors and psoas vision of the joint capsule, unilateral (Anaes.) (Assist.)
50381	Fee: \$672.00	Benefit: 75% = \$504.00
		f, anterior release, involving lengthening of, or division of the hip flexors and psoas vision of the joint capsule, bilateral (Anaes.) (Assist.)
50384	Fee: \$1,179.55	Benefit: 75% = \$884.70
50387	HIP, iliopsoas ten	lon transfer to greater trochanter, or transfer of abdominal musculature to greater

	RGICAL OPERATION	ONS	15. ORTHOPAEDIC
	trochanter, or tran	sfer of adductors to ischium (Anaes.) (Assist.)	
	Fee: \$672.00	Benefit: 75% = \$504.00	
		BRAL PALSY, or other neuromuscular condition under general anaesthesia, performed in the operation	
50390	Fee: \$235.85	Benefit: 75% = \$176.90	
	PELVIS, bone gra	off or shelf procedures for acetabular dysplasia (Ar	naes.) (Assist.)
50393	Fee: \$872.05	Benefit: 75% = \$654.05	
		DYSPLASIA, treatment of, by multiple peri-acetal formed (Anaes.) (Assist.)	bular osteotomy, including internal
50394	Fee: \$2,864.10	Benefit: 75% = \$2148.10	
		SHOULDER, ARM AND FOREARM PRO	OCEDURES
		l abnormalities or duplication of digits, amputation gament or joint reconstruction (Anaes.) (Assist.)	n or splitting of phalanx or
50396	Fee: \$479.10	Benefit: 75% = \$359.35	
	FOREARM, RAD (Anaes.) (Assist.)	OIAL APLASIA OR DYSPLASIA (radial club har	nd), centralisation or radialisation of
50399	Fee: \$950.85	Benefit: 75% = \$713.15	
	TORTICOLLIS, t (Assist.)	pipolar release of sternocleidomastoid muscle and	associated soft tissue (Anaes.)
50402	Fee: \$436.15	Benefit: 75% = \$327.15	
	ELBOW, flexorpl	asty, or tendon transfer to restore elbow function (Anaes.) (Assist.)
50405	Fee: \$593.35	Benefit: 75% = \$445.05	
	SHOULDER, con	genital or developmental dislocation, open reducti	
			ion of (Anaes.) (Assist.)
50408	Fee: \$1,029.40	Benefit: 75% = \$772.05	ion of (Anaes.) (Assist.)
50408	AMPUTATION	Benefit: 75% = \$772.05 S OR RECONSTRUCTIONS FOR CONGENITA , treatment of congenital deficiency of the femur b proximal tibia followed by knee fusion (Ana	AL DEFORMITIES LOWER LIMB y resection of the distal femur and
	AMPUTATION	S OR RECONSTRUCTIONS FOR CONGENITA treatment of congenital deficiency of the femur b	AL DEFORMITIES LOWER LIMB y resection of the distal femur and
	AMPUTATION DEFICIENCY Fee: \$1,351.05 LOWER LIMB D	S OR RECONSTRUCTIONS FOR CONGENITA treatment of congenital deficiency of the femur b proximal tibia followed by knee fusion (Ana	AL DEFORMITIES LOWER LIMB by resection of the distal femur and bases.) (Assist.) of the femur by resection of the distal
50408 50411 50414	AMPUTATION DEFICIENCY Fee: \$1,351.05 LOWER LIMB D	S OR RECONSTRUCTIONS FOR CONGENITA treatment of congenital deficiency of the femur b proximal tibia followed by knee fusion (Ana Benefit: 75% = \$1013.30 85% = \$1266.35 EFICIENCY, treatment of congenital deficiency of	AL DEFORMITIES LOWER LIMB by resection of the distal femur and bases.) (Assist.) of the femur by resection of the distal
50411	AMPUTATION DEFICIENCY. Fee: \$1,351.05 LOWER LIMB D femur and proxim Fee: \$1,822.85 LOWER LIMB D	S OR RECONSTRUCTIONS FOR CONGENITA treatment of congenital deficiency of the femur b proximal tibia followed by knee fusion (Ana Benefit: 75% = \$1013.30 85% = \$1266.35 EFICIENCY, treatment of congenital deficiency of al tibia followed by knee fusion and rotationplasty	AL DEFORMITIES LOWER LIMB by resection of the distal femur and aes.) (Assist.) of the femur by resection of the distal of (Anaes.) (Assist.)
50411	AMPUTATION DEFICIENCY. Fee: \$1,351.05 LOWER LIMB D femur and proxim Fee: \$1,822.85 LOWER LIMB D	S OR RECONSTRUCTIONS FOR CONGENITA treatment of congenital deficiency of the femur b proximal tibia followed by knee fusion (Ana Benefit: 75% = \$1013.30 85% = \$1266.35 EFICIENCY, treatment of congenital deficiency of al tibia followed by knee fusion and rotation plasty Benefit: 75% = \$1367.15 85% = \$1738.15 EFICIENCY, treatment of congenital deficiency of	AL DEFORMITIES LOWER LIMB by resection of the distal femur and aes.) (Assist.) of the femur by resection of the distal of (Anaes.) (Assist.)

T8. SUF	RGICAL OPERATION	ONS	15. ORTHOPAEDIC
	Fee: \$1,115.15	Benefit: 75% = \$836.40	
	TIBIA, FIBULA (fixation (Anaes.) (iency of, transfer of the fibula to tibia, with internal
50423	Fee: \$1,029.40	Benefit: 75% = \$772.05	85% = \$944.70
		TUMO	ROUS CONDITIONS
	DIAPHYSEAL A	CLASIA, removal of lesion	or lesions from bone - 1 approach (Anaes.) (Assist.)
50426	Fee: \$479.10	Benefit: 75% = \$359.35	
	SINGLE	EVEN MULTILEVEL SURC	GERY FOR CHILDREN WITH CEREBRAL PALSY
		INGLE EVENT MULTILE al palsy comprising three or	VEL SURGERY for patients less than 18 years of age with more of the following:
		of one or more contracted i	muscle tendon units by tendon lengthening, muscle muscular lengthening.
	(b) Correction o	f muscle imbalance by tend	on transfer/transfers.
	(c) Correction of	f femoral torsion by rotation	nal osteotomy of the femur.
	(d) Correction o	f tibial torsion by rotational	osteotomy of the tibia.
		f joint instability by varus d if performed, or os calcis le	erotation osteotomy of the femur, subtalar arthrodesis, with engthening.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Ass		, including fluoroscopy and aftercare (Anaes.) (Assist.)
50450	(See para TN.8.118 Fee: \$1,265.25	of explanatory notes to this Ca Benefit: 75% = \$948.95	ategory)
		INGLE EVENT MULTILE al palsy comprising three or	VEL SURGERY for patients less than 18 years of age with more of the following:
		of one or more contracted a ctional lengthening or intran	muscle tendon units by tendon lengthening, muscle nuscular lengthening.
	(b) Correction o	f muscle imbalance by tend	on transfer/transfers.
	(c) Correction of	f femoral torsion by rotation	nal osteotomy of the femur.
	(d) Correction o	f tibial torsion by rotational	osteotomy of the tibia.
	* /	f joint instability by varus d if performed, or os calcis le	erotation osteotomy of the femur, subtalar arthrodesis, with ngthening.
	Conjoint surgery, (Assist.)	conjoint specialist surgeon,	including fluoroscopy and excluding aftercare (Anaes.)
50451	(See para TN.8.118 Fee: \$1,265.25	of explanatory notes to this Ca Benefit: 75% = \$948.95	ategory)
50455	BILATERAL SIN	IGLE EVENT MULTILEV	EL SURGERY for patients less than 18 years of age with

T8. SUF	RGICAL OPERATIONS	15. ORTHOPAEDIC
	diplegic cerebral palsy that comprises:	
	(`) 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.	
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and after	ercare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,432.80 Benefit: 75% = \$1074.60	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises:	s than 18 years of age with
	(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.	
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excl (Assist.)	luding aftercare (Anaes.)
50456	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,432.80 Benefit: 75% = \$1074.60	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilater	
	(`) 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 torsional abnormality of the femur by rotational osteotom;	y and internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and after	ercare (Anaes.) (Assist.)
50460	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,139.25 Benefit: 75% = \$1604.45	
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises bilateral soft tissue surgery and bilateral	
	(a) Lengthening of one or more contracted muscle tendon units by tendon lo recession, fractional lengthening or intramuscular lengthening.	engthening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of torsional abnormality of the femur by rotational osteotomy	y and internal fixation.
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excl (Assist.)	luding aftercare (Anaes.)
50461	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,139.25 Benefit: 75% = \$1604.45	
50465	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral for	

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAED
	bilateral tibial osteotomies.
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(`) Correction of muscle imbalance by tendon transfer/transfers.
	() Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.
	(`) Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,013.10 Benefit: 75% = \$2259.85
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with diplegic cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies and bilateral tibial osteotomies.
	(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) Fee: \$3,013.10 Benefit: 75% = \$2259.85
	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial osteotomies and bilateral foot stabilisation.
	(`) Lengthening of one or more contracted muscle tendon units by tendon lengthening, muscle recession, fractional lengthening or intramuscular lengthening.
	(`) Correction of muscle imbalance by tendon transfer/transfers.
	(`) Correction of abnormal torsion of the femur by rotational osteotomy with internal fixation.
	Correction of abnormal torsion of the tibia by rotational osteotomy with internal fixation.
	(`) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion.
	Conjoint surgery, principal specialist surgeon, including fluoroscopy and aftercare (Anaes.) (Assist.)
50470	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,821.30 Benefit: 75% = \$2866.00
50471	BILATERAL SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of age with cerebral palsy that comprises bilateral soft tissue surgery, bilateral femoral osteotomies, bilateral tibial

T8. SURG	SICAL OPERATIONS	15. ORTHOPAEDIC
	osteotomies and bilateral foot stabilisation.	
	(a) Lengthening of one or more contracted muscle tendon units by tendon length recession, fractional lengthening or intramuscular lengthening.	ening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of abnormal torsion of the femur by rotational osteotomy with inte	ernal fixation.
	(d) Correction of abnormal torsion of the tibia by rotational osteotomy with inter	nal fixation.
	(e) Correction of bilateral pes valgus by os calcis lengthening or subtalar fusion.	
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding (Assist.)	g aftercare (Anaes.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,821.30 Benefit: 75% = \$2866.00	
	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of ag cerebral palsy for the correction of crouch gait including:	e with diplegic
	() Lengthening of one or more contracted muscle tendon units by tendon lengther recession, fractional lengthening or intramuscular lengthening.	ening, muscle
	(`) Correction of muscle imbalance by tendon transfer/transfers.	
	(`) Correction of flexion deformity at the knee by extension osteotomy of the dis internal fixation.	tal femur including
	(`) Correction of patella alta and quadriceps insufficiency by patella tendon short	tening/reconstruction.
	(`) Correction of tibial torsion by rotational osteotomy of the tibia with internal f	ixation.
	(`) 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) Fee: \$4,409.40 Benefit: 75% = \$3307.05	
	SINGLE EVENT MULTILEVEL SURGERY for patients less than 18 years of ag cerebral palsy for the correction of crouch gait including:	e with diplegic
	(a) Lengthening of one or more contracted muscle tendon units by tendon length recession, fractional lengthening or intramuscular lengthening.	ening, muscle
	(b) Correction of muscle imbalance by tendon transfer/transfers.	
	(c) Correction of flexion deformity at the knee by extension osteotomy of the disinternal fixation.	tal femur including
	(d) Correction of patella alta and quadriceps insufficiency by patella tendon shor	tening/reconstruction.
	(e) Correction of tibial torsion by rotational osteotomy of the tibia with internal to	ixation.
50476	(f) Correction of foot instability by os calcis lengthening or subtalar fusion.	

T8. SUF	JRGICAL OPERATIONS 15. O	RTHOPAEDIC
	Conjoint surgery, conjoint specialist surgeon, including fluoroscopy and excluding aftero (Assist.)	eare (Anaes.)
	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,409.40 Benefit: 75% = \$3307.05	
	TREATMENT OF FRACTURES IN PAEDIATRIC PATIENTS	
	RADIUS OR ULNA, distal end of, with open growth plate, treatment of fracture of, by c (Anaes.)	losed reduction
50500	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$285.30 Benefit: 75% = \$214.00 85% = \$242.55	
	RADIUS OR ULNA, distal end of, with open growth plate, treatment of fracture of, by (Anaes.) (Assist.)	ppen reduction
50504	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$380.55 Benefit: 75% = \$285.45 85% = \$323.50	
	RADIUS, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's closed reduction (Anaes.)	fracture, by
50508	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$407.55 Benefit: 75% = \$305.70 85% = \$346.45	
	RADIUS, distal end of, with open growth plate, treatment of Colles', Smith's or Barton's open reduction (Anaes.) (Assist.)	fracture of, by
50512	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$543.80 Benefit: 75% = \$407.85	
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, by closed undertaken in the operating theatre of a hospital (Anaes.)	d reduction
50516	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$366.95 Benefit: 75% = \$275.25	
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, by open (Anaes.) (Assist.)	reduction
50520	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$489.25 Benefit: 75% = \$366.95	
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, in conjundislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monte closed reduction undertaken in the operating theatre of a hospital (Anaes.) (Assist.)	
50524	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$421.30 Benefit: 75% = \$316.00	
	RADIUS OR ULNA, shaft of, with open growth plate, treatment of fracture of, in conjundislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monte reduction with or without internal fixation by open or percutaneous means (Anaes.) (Ass	eggia injury), by
50528	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$679.60 Benefit: 75% = \$509.70	
	RADIUS AND ULNA, shafts of, with open growth plates, treatment of fracture of, by clundertaken in the operating theatre of a hospital (Anaes.)	osed reduction
50532	(See para TN.8.119, TN.8.118 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAE	DIC
	Fee: \$591.30 Benefit: 75% = \$443.50	
	RADIUS AND ULNA, shafts of, with open growth plates, treatment of fracture of, by open reduction (Anaes.) (Assist.)	n
50536	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$788.30 Benefit: 75% = \$591.25	
	OLECRANON, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)
50540	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$543.80 Benefit: 75% = \$407.85	
	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) Fee: \$271.80 Benefit: 75% = \$203.85 85% = \$231.05	
	RADIUS, with open growth plate, treatment of fracture of head or neck of, by reduction with or with internal fixation by open or percutaneous means (Anaes.) (Assist.)	out
50548	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$543.80 Benefit: 75% = \$407.85	
	HUMERUS, proximal, with open growth plate, treatment of fracture of, by closed reduction, undertain the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	ken
50552	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$469.00 Benefit: 75% = \$351.75	
	HUMERUS, proximal, with open growth plate, treatment of fracture of, by open reduction (Anaes.) (Assist.)	
50556	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$625.15 Benefit: 75% = \$468.90	
	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by closed reduction, undertaken in the operating theatre, neonatal unit or nursery of a hospital (Anaes.)	en
50560	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$489.25 Benefit: 75% = \$366.95	
	HUMERUS, shaft of, with open growth plate, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.)	n
50564	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$652.40 Benefit: 75% = \$489.30	
	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital (Anaes.)	
50568	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$570.90 Benefit: 75% = \$428.20	
	HUMERUS, with open growth plate, supracondylar or condylar, treatment of fracture of, by reductio with or without internal fixation by open or percutaneous means, undertaken in the operating theatre hospital (Anaes.) (Assist.)	
50572	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$761.15 Benefit: 75% = \$570.90	
50576	FEMUR, with open growth plate, treatment of fracture of, by closed reduction or traction (Anaes.)	

T8. SUF	RGICAL OPERATIONS 15. ORTHOPAEDI
	(Assist.)
	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$625.15 Benefit: 75% = \$468.90 85% = \$540.45
	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) Fee: \$652.40 Benefit: 75% = \$489.30
	TIBIA, distal, with open growth plate, treatment of fracture of, by reduction with or without internal fixation by open or percutaneous means (Anaes.) (Assist.)
50584	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$625.15 Benefit: 75% = \$468.90
	TIBIA AND FIBULA, with open growth plates, treatment of fracture of, by internal fixation (Anaes.) (Assist.)
50588	(See para TN.8.119, TN.8.118 of explanatory notes to this Category) Fee: \$815.40 Benefit: 75% = \$611.55
	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) Fee: \$448.25 Benefit: 75% = \$336.20
	SCOLIOSIS or KYPHOSIS, in a child or adolescent, spinal fusion for (without instrumentation) (Anaes.) (Assist.)
50604	(See para TN.8.118 of explanatory notes to this Category) Fee: \$1,902.65 Benefit: 75% = \$1427.00
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, treatment by segmental instrumentation and fusion of the spine, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)
50608	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,534.05 Benefit: 75% = \$2650.55
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, with spinal deformity, treatment by segmental instrumentation, utilising separate anterior and posterior approaches, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)
50612	(See para TN.8.118 of explanatory notes to this Category) Fee: \$5,026.80 Benefit: 75% = \$3770.10
	SCOLIOSIS, in a child or adolescent, re-exploration for adjustment or removal of segmental instrumentation used for correction of spine deformity (Anaes.) (Assist.)
50616	(See para TN.8.118 of explanatory notes to this Category) Fee: \$638.70 Benefit: 75% = \$479.05
	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation, not being a service to which item 51011 to 51171 applies (Anaes.) (Assist.)
50620	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,534.05 Benefit: 75% = \$2650.55

T8. SUR	RGICAL OPERATIONS 15. ORT	HOPAEDIO
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixat Zielke or similar) - not more than 4 levels (Anaes.) (Assist.)	tion (Dwyer
50624	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,534.05 Benefit: 75% = \$2650.55	
	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixat Zielke or similar) - more than 4 levels (Anaes.) (Assist.)	tion (Dwyer,
50628	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,365.45 Benefit: 75% = \$3274.10	
	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation of the spine down to and including the pelvis or sacrum, not being a service to which item 5 51171 applies (Anaes.) (Assist.)	
50632	(See para TN.8.118 of explanatory notes to this Category) Fee: \$3,669.85 Benefit: 75% = \$2752.40	
	SCOLIOSIS, in a child or adolescent, requiring anterior decompression of the spinal cord w resection and instrumentation in the presence of spinal cord involvement, not being a service item 51011 to 51171 applies (Anaes.) (Assist.)	
50636	(See para TN.8.118 of explanatory notes to this Category) Fee: \$4,077.60 Benefit: 75% = \$3058.20	
	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra anterior or posterior approach, not being a service to which item 51011 to 51171 applies (Ar (Assist.)	
50640	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,254.05 Benefit: 75% = \$1690.55	
	SPINE, bone graft to, for a child or adolescent, associated with surgery for correction of sco kyphosis or both (Anaes.) (Assist.)	liosis or
50644	(See para TN.8.118 of explanatory notes to this Category) Fee: \$2,174.85 Benefit: 75% = \$1631.15	
	TREATMENT OF HIP DYSPLASIA OR DISLOCATION IN PAEDIATRIC PATIENT	ΓS
	HIP DYSPLASIA or DISLOCATION, in a child, examination, manipulation and arthrograpunder anaesthesia (Anaes.)	hy of the hip
50650	(See para TN.8.118 of explanatory notes to this Category) Fee: \$427.70 Benefit: 75% = \$320.80 85% = \$363.55	
	HIP DYSPLASIA or DISLOCATION, in a child, application or reapplication of a hip spica examination of the hip (Anaes.) (Assist.)	, including
50654	(See para TN.8.118 of explanatory notes to this Category) Fee: \$512.15 Benefit: 75% = \$384.15	
	HIP DYSPLASIA or DISLOCATION, in a child, examination and manipulation of the hip anaesthesia (Anaes.)	under
50658	(See para TN.8.118 of explanatory notes to this Category) Fee: \$203.90 Benefit: 75% = \$152.95 85% = \$173.35	
TR SIIR	16. RADIOFREQUENCY AND MI RGICAL OPERATIONS TISSUE	ICROWAVE ABLATION

T8. SUF	16. RADIOFREQUENCY AND MICROWAVE RGICAL OPERATIONS TISSUE ABLATION
	Group T8. Surgical Operations
	Subgroup 16. Radiofrequency And Microwave Tissue Ablation
	Unresectable primary malignant tumour of the liver, destruction of, by percutaneous radiofrequency ablation or percutaneous microwave tissue ablation (including any associated imaging services), other than a service associated with a service to which item 30419 or 50952 applies
	(Anaes.)
50950	Fee: \$842.60 Benefit: 75% = \$631.95 85% = \$757.90
	Unresectable primary malignant tumour of the liver, destruction of, by open or laparoscopic radiofrequency ablation or open or laparoscopic microwave tissue ablation (including any associated imaging services), if a multi-disciplinary team has assessed that percutaneous radiofrequency ablation or percutaneous microwave tissue ablation cannot be performed or is not practical because of one or more of the following clinical circumstances:
	(a) percutaneous access cannot be achieved;
	(b) vital organs or tissues are at risk of damage from the percutaneous radiofrequency ablation or percutaneous microwave tissue ablation procedure;
	(c) resection of one part of the liver is possible, however there is at least one primary liver tumour in an unresectable portion of the liver that is suitable for radiofrequency ablation or microwave tissue ablation;
	other than a service associated with a service to which item 30419 or 50950 applies.
	(Anaes.)
50952	(See para TN.8.120 of explanatory notes to this Category) Fee: \$842.60 Benefit: 75% = \$631.95 85% = \$757.90
T8. SUF	RGICAL OPERATIONS 17. SPINAL SURGERY
	Group T8. Surgical Operations
	Subgroup 17. Spinal Surgery
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, one motion segment, not being a service associated with a service to which item 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.)
51011	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$1,480.35 Benefit: 75% = \$1110.30
	Spinal decompression or exposure via partial or total laminectomy, partial vertebrectomy or posterior spinal release, 2 motion segments, not being a service associated with a service to which item 51011, 51013, 51014 or 51015 applies (Anaes.) (Assist.)
51012	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$1,973.55 Benefit: 75% = \$1480.20

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	Spinal decompression or exposure via partial or total laminectomy, spinal release, 3 motion segments, not being a service associated w 51012, 51014 or 51015 applies (Anaes.) (Assist.)	
51013	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$2,467.00 Benefit: 75% = \$1850.25	
	Spinal decompression or exposure via partial or total laminectomy, spinal release, 4 motion segments, not being a service associated w 51012, 51013 or 51015 applies (Anaes.) (Assist.)	
51014	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$2,960.40 Benefit: 75% = \$2220.30	
	Spinal decompression or exposure via partial or total laminectomy, spinal release, more than 4 motion segments, not being a service as 51011, 51012, 51013 or 51014 applies (Anaes.) (Assist.)	
51015	(See para TN.8.141, TN.8.142 of explanatory notes to this Category) Fee: \$3,453.80 Benefit: 75% = \$2590.35	
	Simple fixation of part of one vertebra (not motion segment) include process or pedicle, or simple interspinous wiring between 2 adjacent associated with:	
	(a) interspinous dynamic stabilisation devices; or	
	(b) a service to which item 51021, 51022, 51023, 51024, 51025 or	51026 applies (Anaes.) (Assist.)
51020	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$789.35 Benefit: 75% = \$592.05	
	Fixation of motion segment with vertebral body screw, pedicle scresublaminar tapes or wires, one motion segment, not being a service item 51020, 51022, 51023, 51024, 51025 or 51026 applies (Anaes.	e associated with a service to which
51021	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$1,321.25 Benefit: 75% = \$990.95	
	Fixation of motion segment with vertebral body screw, pedicle screwing sublaminar tapes or wires, 2 motion segments, not being a service a item 51020, 51021, 51023, 51024, 51025 or 51026 applies (Anaes.	associated with a service to which
51022	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$1,643.50 Benefit: 75% = \$1232.65	
	Fixation of motion segment with vertebral body screw, pedicle scresublaminar tapes or wires, 3 or 4 motion segments, not being a servitem 51020, 51021, 51022, 51024, 51025 or 51026 applies (Anaes.	vice associated with a service to which
51023	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$1,955.85 Benefit: 75% = \$1466.90	
	Fixation of motion segment with vertebral body screw, pedicle scresublaminar tapes or wires, 5 or 6 motion segments, not being a servitem 51020, 51021, 51022, 51023, 51025 or 51026 applies (Anaes.	vice associated with a service to which
51024	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$2,258.00 Benefit: 75% = \$1693.50	
51025	Fixation of motion segment with vertebral body screw, pedicle scre	ew or hook instrumentation including

T8. SURGICAL OPERATIONS 17. SPINAL S		
	sublaminar tapes or wires, 7 to 12 motion segments, not being a serve which item 51020, 51021, 51022, 51023, 51024 or 51026 applies (A	
	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$2,639.15 Benefit: 75% = \$1979.40	
	Fixation of motion segment with vertebral body screw, pedicle screw sublaminar tapes or wires, more than 12 motion segments, not being to which item 51020, 51021, 51022, 51023, 51024 or 51025 applies	g a service associated with a service
51026	(See para TN.8.141, TN.8.143 of explanatory notes to this Category) Fee: \$2,889.45 Benefit: 75% = \$2167.10	
	Spine, posterior and/or posterolateral bone graft to, one motion segment with a service to which item 51032, 51033, 51034, 51035 or 51036.	
51031	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$970.85 Benefit: 75% = \$728.15	
	Spine, posterior and/or posterolateral bone graft to, 2 motion segment with a service to which item 51031, 51033, 51034, 51035 or 51036	
51032	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,165.05 Benefit: 75% = \$873.80	
	Spine, posterior and/or posterolateral bone graft to, 3 motion segment with a service to which item 51031, 51032, 51034, 51035 or 51036	
51033	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,359.25 Benefit: 75% = \$1019.45	
	Spine, posterior and/or posterolateral bone graft to, 4 to 7 motion se associated with a service to which item 51031, 51032, 51033, 51035	
51034	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,456.30 Benefit: 75% = \$1092.25	
	Spine, posterior and/or posterolateral bone graft to, 8 to 11 motion s associated with a service to which item 51031, 51032, 51033, 51034	
51035	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,553.35 Benefit: 75% = \$1165.05	
	Spine, posterior and/or posterolateral bone graft to, 12 or more moti- associated with a service to which item 51031, 51032, 51033, 51034	
51036	(See para TN.8.141, TN.8.144 of explanatory notes to this Category) Fee: \$1,650.50 Benefit: 75% = \$1237.90	
	Spinal fusion, anterior column (anterior, direct lateral or posterior in being a service associated with a service to which item 51042, 5104 (Assist.)	•
51041	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$1,116.50 Benefit: 75% = \$837.40	
	Spinal fusion, anterior column (anterior, direct lateral or posterior in being a service associated with a service to which item 51041, 5104 (Assist.)	
51042	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$1,563.15 Benefit: 75% = \$1172.40	

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY
	Spinal fusion, anterior column (anterior, direct lateral or posterior inte being 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) Fee: \$1,953.95 Benefit: 75% = \$1465.50	
	Spinal fusion, anterior column (anterior, direct lateral or posterior inte being 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) Fee: \$2,121.40 Benefit: 75% = \$1591.05	
	Spinal fusion, anterior column (anterior, direct lateral or posterior inte segments, not being a service associated with a service to which item applies (Anaes.) (Assist.)	
51045	(See para TN.8.141, TN.8.145 of explanatory notes to this Category) Fee: \$2,233.05 Benefit: 75% = \$1674.80	
	Pedicle subtraction osteotomy, one vertebra, not being a service associtem 51052, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 app	
51051	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$1,907.80 Benefit: 75% = \$1430.85	
	Pedicle subtraction osteotomy, 2 vertebrae, not being a service association 51051, 51053, 51054, 51055, 51056, 51057, 51058 or 51059 app	
51052	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,320.30 Benefit: 75% = \$1740.25	
	Vertebral column resection osteotomy performed through single poste being a service associated with a service to which item 51051, 51052, 51058 or 51059 applies (Anaes.) (Assist.)	
51053	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,639.95 Benefit: 75% = \$1980.00	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or removal of more than 50% of the vertebral body), one vertebra, not be	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51055, 51056, 5105 (Assist.)	7, 51058 or 51059 applies (Anaes.)
51054	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$1,407.65 Benefit: 75% = \$1055.75	
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or removal of more than 50% of the vertebral body), 2 vertebrae, not bein	
	(a) anterior column fusion when at the same motion segment; or	
	(b) a service to which item 51051, 51052, 51053, 51054, 51056, 5105 (Assist.)	7, 51058 or 51059 applies (Anaes.)
51055	(See para TN.8.141, TN.8.146 of explanatory notes to this Category)	

T8. SUF	RGICAL OPERATIONS	17. SPINAL SURGERY				
	Fee: \$2,111.45 Benefit: 75% = \$1583.60					
	Vertebral body, piecemeal or subtotal excision of (where piecemeal or suremoval of more than 50% of the vertebral body), 3 or more vertebrae, n with:					
	(a) anterior column fusion when at the same motion segment; or					
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51057, (Assist.)	51058 or 51059 applies (Anaes.)				
51056	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,463.35 Benefit: 75% = \$1847.55					
	Vertebral body, en bloc excision of (complete spondylectomy), one verte associated with:	ebra, 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, (Assist.)	51058 or 51059 applies (Anaes.)				
51057	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,475.00 Benefit: 75% = \$1856.25					
	Vertebral body, en bloc excision of (complete spondylectomy), 2 vertebral associated with:	rae, 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, (Assist.)	51057 or 51059 applies (Anaes.)				
51058	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$2,784.85 Benefit: 75% = \$2088.65					
	Vertebral body, en bloc excision of (complete spondylectomy), 3 or mor associated with:	re vertebrae, not being a service				
	(a) anterior column fusion when at the same motion segment; or					
	(b) a service to which item 51051, 51052, 51053, 51054, 51055, 51056, (Assist.)	51057 or 51058 applies (Anaes.)				
51059	(See para TN.8.141, TN.8.146 of explanatory notes to this Category) Fee: \$3,403.10 Benefit: 75% = \$2552.35					
	Spinal fusion, anterior and posterior, including spinal instrumentation at and/or posterolateral bone graft, and anterior column fusion, not being a to which item 51062, 51063, 51064, 51065 or 51066 applies (Anaes.) (A	service associated with a service				
51061	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$2,923.20 Benefit: 75% = \$2192.40					
	Spinal fusion, anterior and posterior, including spinal instrumentation at and/or posterolateral bone graft, and anterior column fusion, not being a to which item 51061, 51063, 51064, 51065 or 51066 applies (Anaes.) (A	service associated with a service				
51062	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$3,789.15 Benefit: 75% = \$2841.90					

T8. SURGICAL OPERATIONS 17. SPINAL SU		17. SPINAL SURGERY
	Spinal fusion, anterior and posterior, including spinal instrumentati and/or posterolateral bone graft, and anterior column fusion, not be to which item 51061, 51062, 51064, 51065 or 51066 applies (Anae	ing a service associated with a service
51063	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$4,589.35 Benefit: 75% = \$3442.05	
	Spinal fusion, anterior and posterior, including spinal instrumentati posterior and/or posterolateral bone graft, and anterior column fusion with a service to which item 51061, 51062, 51063, 51065 or 51066	on, not being a service associated
51064	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,107.60 Benefit: 75% = \$3830.70	
	Spinal fusion, anterior and posterior, including spinal instrumentati posterior and/or posterolateral bone graft, and anterior column fusion with a service to which item 51061, 51062, 51063, 51064 or 51066	on, not being a service associated
51065	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,648.95 Benefit: 75% = \$4236.75	
	Spinal fusion, anterior and posterior, including spinal instrumentati posterior and/or posterolateral bone graft, and anterior column fusion a service to which item 51061, 51062, 51063, 51064 or 51065 apple	on not being a service associated with
51066	(See para TN.8.141, TN.8.147 of explanatory notes to this Category) Fee: \$5,947.70 Benefit: 75% = \$4460.80	
	Removal of intradural lesion, not being a service associated with a applies (Anaes.) (Assist.)	service to which item 51072 or 51073
51071	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,578.10 Benefit: 75% = \$1933.60	
	Craniocervical junction lesion, transoral approach for, not being a swhich item 51071 or 51073 applies (Anaes.) (Assist.)	service associated with a service to
51072	(See para TN.8.141 of explanatory notes to this Category) Fee: \$2,681.20 Benefit: 75% = \$2010.90	
	Removal of intramedullary tumour or arteriovenous malformation, service to which item 51071 or 51072 applies (Anaes.) (Assist.)	not being a service associated with a
51073	(See para TN.8.141 of explanatory notes to this Category) Fee: \$3,403.10 Benefit: 75% = \$2552.35	
	Thoracoplasty in combination with thoracic scoliosis correction—3	3 or more ribs (Anaes.) (Assist.)
51102	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,220.40 Benefit: 75% = \$915.30	
	Odontoid screw fixation (Anaes.) (Assist.)	
51103	(See para TN.8.141, TN.8.148 of explanatory notes to this Category) Fee: \$2,144.75 Benefit: 75% = \$1608.60	
	Spine, treatment of fracture, dislocation or fracture dislocation, with not including application of skull tongs or calipers as part of operat	
51110	(See para TN.8.141 of explanatory notes to this Category) Fee: \$776.80 Benefit: 75% = \$582.60 85% = \$692.10	

T8. SUF	RGICAL OPERATIONS 17. SPINAL SURGER
	Skull calipers or halo, insertion of, as an independent procedure (Anaes.)
51111	(See para TN.8.141 of explanatory notes to this Category) Fee: \$330.15 Benefit: 75% = \$247.65
	Plaster jacket, application of, as an independent procedure (Anaes.)
51112	(See para TN.8.141 of explanatory notes to this Category) Fee: \$223.25 Benefit: 75% = \$167.45 85% = \$189.80
	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) Fee: \$247.55 Benefit: 75% = \$185.70
	Halo thoracic orthosis—application of both halo and thoracic jacket (Anaes.)
51114	(See para TN.8.141 of explanatory notes to this Category) Fee: \$437.00 Benefit: 75% = \$327.75
	Halo femoral traction, as an independent procedure (Anaes.)
51115	(See para TN.8.141 of explanatory notes to this Category) Fee: \$437.00 Benefit: 75% = \$327.75 85% = \$371.45
	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) Fee: \$242.85 Benefit: 75% = \$182.15
	Lumbar artificial intervertebral total disc replacement, at one motion segment only, including removal disc and marginal osteophytes:
	(a) for a patient who:
	(i) has not had prior spinal fusion surgery at the same lumbar level; and
	(ii) does not have vertebral osteoporosis; and
	(iii) has failed conservative therapy; and
	(b) not being a service associated with a service to which item 51011, 51012, 51013, 51014 or 51015 applies (Anaes.) (Assist.)
51130	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,849.70 Benefit: 75% = \$1387.30
	Cervical artificial intervertebral total disc replacement, at one motion segment only, including removal of disc and marginal osteophytes, for a patient who:
	(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
51131	(d) does not have vertebral osteoporosis; and

T8. SURGICAL OPERATIONS 17. SPINAL SU		
	(e) has failed conservative therapy (Anaes.) (Assist.)	
	(See para TN.8.141 of explanatory notes to this Category) Fee: \$1,116.50 Benefit: 75% = \$837.40	
	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) Fee: \$456.30 Benefit: 75% = \$342.25	
	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 (Anac (Assist.)	
51141	(See para TN.8.141 of explanatory notes to this Category) Fee: \$844.10 Benefit: 75% = \$633.10	
	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) Fee: \$456.30 Benefit: 75% = \$342.25	
	Coccyx, excision of (Anaes.) (Assist.)	
51150	(See para TN.8.141 of explanatory notes to this Category) Fee: \$459.35 Benefit: 75% = \$344.55	
	Anterior exposure of thoracic or lumbar spine, one motion segment, not being a service to which ite 51165 applies (Anaes.) (Assist.)	em
51160	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) Fee: \$1,185.95 Benefit: 75% = \$889.50	
	Anterior exposure of thoracic or lumbar spine, more than one motion segment, not being a service t which item 51160 applies (Anaes.) (Assist.)	О
51165	(See para TN.8.141, TN.8.149 of explanatory notes to this Category) Fee: \$1,495.30 Benefit: 75% = \$1121.50	
	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) Fee: \$2,252.85 Benefit: 75% = \$1689.65	
	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) Fee: \$946.10 Benefit: 75% = \$709.60	
T9. ASS	SISTANCE AT OPERATIONS	
	Group T9. Assistance At Operations	
51300	Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$575 or at a series or combination of operations identified by the word "Assist." where the fee for the sericombination of operations identified by the word "Assist." does not exceed \$575.75	

19. ASS	SISTANCE AT OPERATIONS
	(See para TN.9.2, TN.9.1 of explanatory notes to this Category) Fee: \$89.00 Benefit: 75% = \$66.75 85% = \$75.65
	Assistance at any operation identified by the word "Assist." for which the fee exceeds \$575.75 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$575.75
51303	(See para TN.9.1, TN.9.3 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the operation or combination of operations
	Assistance at a birth involving Caesarean section
51306	(See para TN.9.1 of explanatory notes to this Category) Fee: \$128.55 Benefit: 75% = \$96.45 85% = \$109.30
	Assistance at a series or combination of operations that include "(Assist.)" and assistance at a birth involving Caesarean section
51309	(See para TN.9.1, TN.9.4 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)
	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615 and 16627
51312	(See para TN.4.11, TN.9.1 of explanatory notes to this Category) Derived Fee: one fifth of the established fee for the procedure or combination of procedures
	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707, when performed in association with services covered by item 42551 to 42569, 42653, 42656, 42725, 42746, 42749, 42752, 42776 or 42779
51315	(See para TN.9.1 of explanatory notes to this Category) Fee: \$280.90 Benefit: 75% = \$210.70 85% = \$238.80
	Assistance at cataract and intraocular lens surgery where patient has:
	- total loss of vision, including no potential for central vision, in the fellow eye; or
	- previous significant surgical complication in the fellow eye; or
	- pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage
51318	(See para TN.9.5, TN.9.1 of explanatory notes to this Category) Fee: \$185.40 Benefit: 75% = \$139.05 85% = \$157.60
ANAES ONLY P PERFO	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 1. HEAD
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 1. Head
20100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

1. HEAD

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	which another it	em in this Subgroup applies (5 basic units)
	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units)
20102	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units)
20104	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner opsy, not being a service to which another item in this Subgroup applies (5 basic units)
20120	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units)
20124	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to
	which another it	em in this Group applies (5 basic units)
20140	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for lens surgery (5 basic units)
	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
20142	Extended Medi	care Safety Net Cap: \$81.60
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units)
20143	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for corneal transplant (7 basic units)
20144	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for vitrectomy (7 basic units)
20145	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units)
20146	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for squint repair (6 basic units)
20147	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units)
20148	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		management of anaesthesia for intranasal or accessory sinuses, not being a service to em in this Subgroup applies (6 basic units)
20160	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
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T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

1. HEAD

	Initiation of the management of anaesthesia for intranasal surgery for malignancy or for intranasal ablation (7 basic units)
20162	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units)
20164	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (6 basic units)
20170	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units)
20172	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units)
20174	Fee: \$183.60 Benefit: 75% = \$137.70 85% = \$156.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units)
20176	Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units)
20190	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units)
20192	Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units)
20210	Fee: \$306.00 Benefit: 75% = \$229.50 85% = \$260.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units)
20212	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units)
20214	Fee: \$183.60 Benefit: 75% = \$137.70 85% = \$156.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units)
20216	Fee: \$408.00 Benefit: 75% = \$306.00 85% = \$346.80
20220	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units)
20220	

ANAES ONLY F PERFO	PAYABLE FOR A	ARE BENEFITS ARE
	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic
20222	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units)
20225	Fee: \$244.80	Benefit: 75% = \$183.60 85% = \$208.10
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery ad or face (12 basic units)
	(See para TN.10.2)	8 of explanatory notes to this Category)
20230	Fee: \$244.80	Benefit: 75% = \$183.60 85% = \$208.10

2. NECK

		ntive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rformed In Association With An Eligible Service
		Subgroup 2. Neck
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous a not being a service to which another item in this Subgroup applies (5 basic units)
20300	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
		F MANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, llulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15
20305	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10
	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: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
		F MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, ctomy or pharyngectomy (10 basic units)
20321	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF and mouth) (8 ba	F MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose asic units)
20330	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
20350	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not

	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE
ONLY P	AYABLE FOR ANAESTHESIA
	RMED IN ASSOCIATION WITH AN LE SERVICE 2. NECI
	being a service to which another item in this Subgroup applies (10 basic units)
	Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units)
20352	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the neck (12 basic units)
20355	(See para TN.10.28 of explanatory notes to this Category) Fee: \$244.80 Benefit: 75% = \$183.60 85% = \$208.10
ANAEST ONLY P PERFOR	LATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN LE SERVICE 3. THORA
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 3. Thorax
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units)
20400	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units)
20401	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units)
20402	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units)
20403	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units)
20404	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units)
20405	Fee: \$163.20 Benefit: 75% = \$122.40 85% = \$138.75

INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE breast with internal mammary node dissed Fee: \$265.20 Benefit: 75% = \$198

3. THORAX

	breast with inter	nal mammary node dissection (13 basic units)
	Fee: \$265.20	Benefit: 75% = \$198.90 85% = \$225.45
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (4
20410	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous terior part of the chest not being a service to which another item in this Subgroup applies
20420	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION Of sternum (4 basic	F MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the units)
20440	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum ce to which another item in this Subgroup applies (5 basic units)
20450	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF sternum (6 basic	F MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or units)
20452	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
		F MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to em in this Subgroup applies (6 basic units)
20470	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units)
20472	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic
		2 of explanatory notes to this Category)
20474	Fee: \$265.20	Benefit: 75% = \$198.90 85% = \$225.45
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery terior or posterior thorax (10 basic units)
		8 of explanatory notes to this Category)
20475	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

4. INTRATHORACIC

4. INTRATHORACIC

	Crown T40, Bolo	tive Value Cuide For Apposthagia Medicare Panelite Are Only Payable For	
		tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For formed In Association With An Eligible Service	
		Subgroup 4. Intrathoracic	
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15	
20500	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10	
		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: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units)	
20522	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units)	
20524	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units)	
20526	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units)	
20528	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75	
		MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, n, or mediastinum, not being a service to which another item in this Subgroup applies	
20540	Fee: \$265.20	Benefit: 75% = \$198.90 85% = \$225.45	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units)	
20542	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10	
	INITIATION OF (15 basic units)	MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty	
20546	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units)		
20548	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10	
	Initiation of the management of anaesthesia for:		
	(a) open procedur	res on the heart, pericardium or great vessels of the chest; or	
20560	(b) percutaneous	insertion of a valvular prosthesis (20 basic units)	

4. INTRATHORACIC

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN

5. SPINE AND SPINAL CORD

ELIGIB	LE SERVICE	5. SPINE AND SPINAL CORD
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 5. Spine And Spinal Cord
	not being a servi	F MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, ice to which another item in this Subgroup applies (for myelography and discography and 21914) (10 basic units)
20600	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
		F MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the ting position (13 basic units)
20604	Fee: \$265.20	Benefit: 75% = \$198.90 85% = \$225.45
		F MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, ice to which another item in this Subgroup applies (10 basic units)
20620	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic
20622	Fee: \$265.20	Benefit: 75% = \$198.90 85% = \$225.45
		F MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a another item in this Subgroup applies (8 basic units)
20630	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units)
20632	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units)
20634	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION Of procedures (13 b	F MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord pasic units)
20670	(See para TN.10.2 Fee: \$265.20	23 of explanatory notes to this Category) Benefit: 75% = \$198.90 85% = \$225.45
		F MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in eatre of a hospital (3 basic units)
20680	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05

5. SPINE AND SPINAL CORD

INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units)

20690 **Fee:** \$102.00 **Benefit:** 75% = \$76.50 85% = \$86.70

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
		e Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For rmed In Association With An Eligible Service
		Subgroup 6. Upper Abdomen
		ANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous nterior abdominal wall, not being a service to which another item in this Subgroup s)
20700	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05
	INITIATION OF M	ANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)
20702	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		ANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, of the upper abdominal wall, not being a service to which another item in this basic units)
20703	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		ANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery or or posterior upper abdomen (10 basic units)
20704	(See para TN.10.28 of Fee: \$204.00	explanatory notes to this Category) Benefit: 75% = \$153.00 85% = \$173.40
		agement of anaesthesia for laparoscopic procedures in the upper abdomen, including ystectomy, not being a service to which another item in this Subgroup applies (7
20706	(See para TN.10.27 of Fee: \$142.80	explanatory notes to this Category) Benefit: 75% = \$107.10 85% = \$121.40
		ANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous osterior abdominal wall, not being a service to which another item in this Subgroup s)
20730	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF M procedures (5 basic	ANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic units)
20740	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70

6. UPPER ABDOMEN

	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	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40
	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) Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units)
20752	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units)
20754	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units)
20756	Fee: \$183.60 Benefit: 75% = \$137.70 85% = \$156.10
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units)
20770	Fee: \$306.00 Benefit: 75% = \$229.50 85% = \$260.10
	Initiation of the management of anaesthesia for procedures within the peritoneal cavity in upper abdomen, including any of the following: (a) open cholecystectomy; (b) gastrectomy; (c) laparoscopically assisted nephrectomy; (d) bowel shunts (8 basic units)
20790	Fee: \$163.20 Benefit: 75% = \$122.40 85% = \$138.75
	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) Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units)
20792	Fee: \$265.20 Benefit: 75% = \$198.90 85% = \$225.45
	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units)
20793	Fee: \$306.00 Benefit: 75% = \$229.50 85% = \$260.10

6. UPPER ABDOMEN

	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic
20794	Fee: \$244.80	Benefit: 75% = \$183.60 85% = \$208.10
	INITIATION Of upper abdomen (F MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the (10 basic units)
20798	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
		F MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra- in the upper abdomen (6 basic units)
20799	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE 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	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units)	
20802	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures on the nerves, muscles, tendons and fascia of the lower abdominal wall, not being a service to which another item in this Subgroup applies (4 basic units)	
20803	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior lower abdomen (10 basic units)	
	(See para TN.10.28 of explanatory notes to this Category)	
20804	Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units)	
20806	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40	
20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4	

7. LOWER ABDOMEN

ELIGIB	LE SERVICE	7. LOWER ABDOMEN
	basic units)	
	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION Of urinary tract (6 b	F MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to pasic units)
20815	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or sue of the lower posterior abdominal wall (5 basic units)
20820	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
		F MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being ch another item in this Subgroup applies (4 basic units)
20830	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound e lower abdomen (6 basic units)
20832	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
20840	peritoneal cavity applies (6 basic	management of anaesthesia for all open procedures within the lower abdominal y, including appendicectomy, not being a service to which another item in this Subgroup units) 27 of explanatory notes to this Category) Benefit: 75% = \$91.80 85% = \$104.05
		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: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units)
20842	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull ares, ultra low anterior resection and formation of bowel reservoir (10 basic units)
20844	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units)
20845	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units)
20846	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for ovarian malignancy (10 basic units)
20847	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
20848	INITIATION O	F MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units)

7. LOWER ABDOMEN

	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units)		
20850	Fee: \$244.80	Benefit: 75% = \$183.60 85% = \$208.10	
20030		F MANAGEMENT OF ANAESTHESIA for Caesarean hysterectomy or hysterectomy	
		of birth (15 basic units)	
20855	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower	
	abdomen, includation applies (6 basic	ing those on the urinary tract, not being a service to which another item in this Subgroup	
	applies (6 basic		
20860	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05	
	INITIATION Of ureter (7 basic u	F MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of	
	,		
20862	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40	
		F MANAGEMENT OF ANAESTHESIA for nephrectomy (10 basic units)	
20863	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units)	
20864	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units)	
20866	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
		F MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the	
	lower abdomen	(10 basic units)	
20867	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
		F MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient)	
	(10 basic units)		
20868	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
		F MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal g a service to which another item in this subgroup applies (15 basic units)	
20880	Fee: \$306.00	Benefit: 75% = \$229.50	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units)	
20882	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic	
20884	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70	
20886		F MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-	

T10. RELATIVE VALUE GUIDE FOR
ANAESTHESIA - MEDICARE BENEFITS ARE
ONLY PAYABLE FOR ANAESTHESIA
PERFORMED IN ASSOCIATION WITH AN
ELIGIBLE SERVICE

7. LOWER ABDOMEN

Fee: \$122.40 **Benefit:** 75% = \$91.80 85% = \$104.05

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

8. PERINEUM

	7	
		ative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For erformed In Association With An Eligible Service
		Subgroup 8. Perineum
		F MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous neum not being a service to which another item in this Subgroup applies (3 basic units)
20900	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05
		management of anaesthesia for anorectal procedures (including surgical omy, but not banding of haemorrhoids) (4 basic units)
20902	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for radical perineal procedures including prostatectomy or radical vulvectomy (7 basic units)
20904	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap sur involving the perineum (10 basic units)	
		8 of explanatory notes to this Category)
20905	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units)
20906	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocystoscopy), not being a service to which another item in this Subgroup applies (4 basic units)	
20910	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for endoscopic ureteroscopic surgery procedures (5 basic units)
20911	(See para TN.10.2 Fee: \$102.00	9 of explanatory notes to this Category) Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units)	
20912	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
20914	INITIATION O	F MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic

8. PERINEUM

	units)
	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units)
20916	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40
	Initiation of management of anaesthesia for procedures on external genitalia, not being a service to which another item in this Subgroup applies. (4 basic units)
20920	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units)
20924	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units)
20926	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units)
20928	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units)
20930	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units)
20932	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units)
20934	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units)
20936	Fee: \$163.20 Benefit: 75% = \$122.40 85% = \$138.75
	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units)
20938	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (4 basic units)

8. PERINEUM

Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
INITIATION OF	F MANAGEMENT OF ANAESTHESIA for vaginal procedures including repair	
operations and urinary incontinence procedures (perineal) (5 basic units)		
Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70	
INITIATION OF (4 basic units)	F MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services	
Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
INITIATION OF	F MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units)	
Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05	
INITIATION OF	F MANAGEMENT OF ANAESTHESIA for vaginal birth (8 basic units)	
Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75	
	F MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal gature (4 basic units)	
Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
INITIATION OF	F MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units)	
Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70	
INITIATION OF	F MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units)	
Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
INITIATION OF units)	F MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic	
Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
	F MANAGEMENT OF ANAESTHESIA for evacuation of retained products of complication of confinement (4 basic units)	
Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
INITIATION OF MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or fo repair of vaginal or perineal tear following birth (5 basic units)		
Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70	
	F MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of norrhage (blood loss > 500mls) (7 basic units)	
Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40	
	INITIATION OF operations and units Fee: \$102.00 INITIATION OF (4 basic units) Fee: \$81.60 INITIATION OF Fee: \$122.40 INITIATION OF of purse string lights Fee: \$81.60 INITIATION OF Fee: \$102.00 INITIATION OF Fee: \$81.60 INITIATION OF Fee: \$81.60 INITIATION OF Fee: \$81.60 INITIATION OF INITIATION OF Units) Fee: \$81.60 INITIATION OF Conception, as a fee: \$81.60 INITIATION OF INITI	

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

9. PELVIS (EXCEPT HIP)

9. PELVIS (EXCEPT HIP)

LLIGIB	LE SERVICE 9. PELVIS (EXCEPT HIP)	
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 9. Pelvis (Except Hip)	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units)	
21100	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units)	
21110	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units)	
21112	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units)	
21114	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous bone marrow harvesting from the pelvis (6 basic units)	
21116	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units)	
21120	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital (3 basic units)	
21130	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units)	
21140	Fee: \$306.00 Benefit: 75% = \$229.50 85% = \$260.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units)	
21150	Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery involving the anterior or posterior pelvis (10 basic units)	
21155	(See para TN.10.28 of explanatory notes to this Category) Fee: \$204.00 Benefit: 75% = \$153.00 85% = \$173.40	
21160	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis	

9. PELVIS (EXCEPT HIP)

	pubis or sacroiliac joint when performed in the operating theatre of a hospital (4 basic units)		
	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
		MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis c joint (8 basic units)	
21170	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75	

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)

10. OTTER EEG (EXCELT RIV			10.011 21. 220 (2.021 1 1.1122)
		ative Value Guide For Anaesthesia rformed In Association With An E	- Medicare Benefits Are Only Payable For igible Service
		Subgroup 10. Upp	er Leg (Except Knee)
		F MANAGEMENT OF ANAESTH er leg (3 basic units)	ESIA for procedures on the skin or subcutaneous
21195	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$	52.05
		F MANAGEMENT OF ANAESTH of the upper leg (4 basic units)	ESIA for procedures on nerves, muscles, tendons,
21199	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$	69.40
		F MANAGEMENT OF ANAESTH operating theatre of a hospital (4 ba	ESIA for closed procedures involving hip joint when sic units)
21200	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$	69.40
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTH	ESIA for arthroscopic procedures of the hip joint (4
21202	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$	69.40
		F MANAGEMENT OF ANAESTH to which another item in this Subgrou	ESIA for open procedures involving hip joint, not up applies (6 basic units)
21210	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$	104.05
	INITIATION O	F MANAGEMENT OF ANAESTH	ESIA for hip disarticulation (10 basic units)
21212	Fee: \$204.00	Benefit: 75% = \$153.00 85% =	\$173.40
	INITIATION Of units)	F MANAGEMENT OF ANAESTH	ESIA for total hip replacement or revision (10 basic
21214	Fee: \$204.00	Benefit: 75% = \$153.00 85% =	\$173.40
21216	INITIATION Of units)	F MANAGEMENT OF ANAESTH	ESIA for bilateral total hip replacement (14 basic

10. UPPER LEG (EXCEPT KNEE)

		10. 011 ER 223 (EXOLI 1 RIVEL)
	Fee: \$285.60	Benefit: 75% = \$214.20 85% = \$242.80
		F MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of formed in the operating theatre of a hospital (4 basic units)
21220	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		F MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 of g a service to which another item in this Subgroup applies (6 basic units)
21230	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units)
21232	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION Of (8 basic units)	F MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur
21234	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
		F MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, ration (4 basic units)
21260	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
l		F MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, s graft, not being a service to which another item in this Subgroup applies (8 basic units)
21270	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
<u> </u>	INITIATION O	F MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units)
21272	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units)
21274	(See para TN.10.2 Fee: \$122.40	24 of explanatory notes to this Category) Benefit: 75% = \$91.80 85% = \$104.05
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery oper leg (10 basic units)
21275	(See para TN.10.2 Fee: \$204.00	28 of explanatory notes to this Category) Benefit: 75% = \$153.00 85% = \$173.40
- 	INITIATION Of (15 basic units)	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg
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T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

11. KNEE AND POPLITEAL AREA

Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For

11. KNEE AND POPLITEAL AREA

	Anaesthesia Perf	ormed In Association With An Eligible Service	
		Subgroup 11. Knee And Popliteal Area	
		MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous and/or popliteal area (3 basic units)	
21300	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05	
		MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, knee and/or popliteal area (4 basic units)	
21321	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
		MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur the operating theatre of a hospital (4 basic units)	
21340	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF basic units)	MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5	
21360	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70	
		MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when perating theatre of a hospital (3 basic units)	
21380	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units)		
21382	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
	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)		
21390	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units)		
21392	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
		MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a nother item in this Subgroup applies (4 basic units)	
21400	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units)	
21402	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40	
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units)	
21403	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units)		

11. KNEE AND POPLITEAL AREA

	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair		
	involving knee j	oint, undertaken in a hospital (3 basic units)	
21420	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05	
		F MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal	
	area, not being a	service to which another item in this Subgroup applies (4 basic units)	
21430	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
		F MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or	
	popliteal area (5 basic units)		
21432	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or popliteal		
	area, not being a service to which another item in this Subgroup applies (8 basic units)		
21440	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75	
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery	
	involving the kn	ee and/or popliteal area (10 basic units)	
	(See para TN.10.28 of explanatory notes to this Category)		
21445	Fee: \$204.00		

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)

LLIGID	LE SERVICE 12. LOWER LEG (BELOW RIVE)
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
	Subgroup 12. Lower Leg (Below Knee)
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units)
21460	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units)
21461	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units)
21462	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05
21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4

12. LOWER LEG (BELOW KNEE)

	basic units)	
	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units)
21472	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units)
21474	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
		F MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, acluding amputation, not being a service to which another item in this Subgroup applies
21480	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION Of leg, ankle or foo	F MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower t (5 basic units)
21482	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION Of (5 basic units)	F MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula
21484	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION O	F MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units)
21486	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40
		F MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or en in a hospital (3 basic units)
21490	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05
		F MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg, s graft, not being a service to which another item in this Subgroup applies (8 basic units)
21500	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
	INITIATION Of units)	F MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic
21502	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
		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: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5
21522	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
21530	INITIATION O	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg,

12. LOWER LEG (BELOW KNEE)

	ankle or foot (15 basic units)	
	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10
	INITIATION Of basic units)	F MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8
21532	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
		F MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery wer leg (10 basic units)
	(See para TN.10.2	8 of explanatory notes to this Category)
21535	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

13. SHOULDER AND AXILLA

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service	
	Subgroup 13. Shoulder And Axilla	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units)	
21600	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units)	
21610	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital (4 basic units)	
21620	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units)	
21622	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units)	
21630	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
21632	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units)	
21032		

13. SHOULDER AND AXILLA

	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units)
21634	Fee: \$183.60	Benefit: 75% = \$137.70 85% = \$156.10
	INITIATION OF amputation (15 b	MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) asic units)
21636	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units)
21638	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
		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: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
	INITIATION OF (10 basic units)	MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm
21652	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF axilla (8 basic un	MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or its)
21654	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic
21656	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
	INITIATION OF (4 basic units)	MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla
21670	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		MANAGEMENT OF ANAESTHESIA for shoulder cast application, removal or a service to which another item in this Subgroup applies, when undertaken in a hospital
21680	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05
		MANAGEMENT OF ANAESTHESIA for shoulder spica application when ospital (4 basic units)
21682	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery pulder or the axilla (10 basic units)
21685	(See para TN.10.28 Fee: \$204.00	8 of explanatory notes to this Category) Benefit: 75% = \$153.00 85% = \$173.40

14. UPPER ARM AND ELBOW

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 14. Upper Arm And Elbow		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units)		
21700	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units)		
21710	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units)		
21712	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units)		
21714	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units)		
21716	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital (3 basic units)		
21730	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units)		
21732	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units)		
21740	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units)		
21756	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units)		
21760	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40		
21770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not		

14. UPPER ARM AND ELBOW

	being a service to	which another item in this Subgroup applies (8 basic units)	
	Fee: \$163.20 Benefit: 75% = \$122.40 85% = \$138.75		
	INITIATION OF (6 basic units)	MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm	
21772	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05	
		MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not which another item in this Subgroup applies (4 basic units)	
21780	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
		MANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery per arm or elbow (10 basic units)	
	(See para TN.10.28	3 of explanatory notes to this Category)	
21785	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION OF (15 basic units)	MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm	
21790	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10	

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 Anaesthesia Performed In Association With An Eligible Service	e For
	Subgroup 15. Forearm Wrist And Hand	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subc tissue of the forearm, wrist or hand (3 basic units)	utaneous
21800	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, must endons, fascia, or bursae of the forearm, wrist or hand (4 basic units)	cles,
21810	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the radiu wrist, or hand bones when performed in the operating theatre of a hospital (3 basic units)	s, ulna,
21820	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the radius, or hand bones, not being a service to which another item in this Subgroup applies (4 basic ur	
21830	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40	

15. FOREARM WRIST AND HAND

	INITIATION OF	MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units))
21832	Fee: \$142.80	Benefit: 75% = \$107.10 85% = \$121.40	
	INITIATION OF (4 basic units)	MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist j	oint
21834	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
		MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, g a service to which another item in this Subgroup applies (8 basic units)	wrist
21840	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75	
	INITIATION OF hand (6 basic unit	F MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrts)	rist or
21842	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05	
		MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, we ga service to which another item in this Subgroup applies (4 basic units)	rist
21850	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40	
		FMANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application when rendered to a patient as part of an episode of hospital treatment (3 basic units).	
21860	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05	
		FMANAGEMENT OF ANAESTHESIA for microvascular free tissue flap surgery earm, wrist or hand (10 basic units)	,
21865	(See para TN.10.2 Fee: \$204.00	8 of explanatory notes to this Category) Benefit: 75% = \$153.00 85% = \$173.40	
	INITIATION OF wrist or hand (15	MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forea basic units)	rm,
21870	Fee: \$306.00	Benefit: 75% = \$229.50 85% = \$260.10	
	INITIATION Of basic units)	MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a fing	ger (8
21872	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75	
		GUIDE FOR ARE BENEFITS ARE NAESTHESIA	
ONLY P		IATION WITH AN 16. ANAESTHESIA FOR BL	JRNS
ONLY P	RMED IN ASSOC LE SERVICE Group T10. Rela	IATION WITH AN	JRNS
ONLY P	RMED IN ASSOC LE SERVICE Group T10. Rela	IATION WITH AN 16. ANAESTHESIA FOR BU tive Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For	JRNS

16. ANAESTHESIA FOR BURNS

ELIGIBI	LE SERVICE 10. ANAESTHESIA FOR BUR	
	without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units)	
	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units)	or
21879	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units)	or
21880	Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units)	or
21881	Fee: \$183.60 Benefit: 75% = \$137.70 85% = \$156.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units)	or
21882	Fee: \$224.40 Benefit: 75% = \$168.30 85% = \$190.75	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units)	or
21883	Fee: \$265.20 Benefit: 75% = \$198.90 85% = \$225.45	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units)	or
21884	Fee: \$306.00 Benefit: 75% = \$229.50 85% = \$260.10	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units)	or
21885	Fee: \$346.80 Benefit: 75% = \$260.10 85% = \$294.80	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units)	or
21886	Fee: \$387.60 Benefit: 75% = \$290.70 85% = \$329.50	
	T	
	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with a without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic un	iits)

17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 17. Anaesthesia For Radiological Or Other Diagnostic Or Therapeutic Procedures		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units)		
21900	Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units)		
21906	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units)		
21908	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units)		
21910	Fee: \$183.60 Benefit: 75% = \$137.70 85% = \$156.10		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units)		
21912	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units)		
21914	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units)		
21915	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units)		
21916	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units)		
21918	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (6 basic units)		
21922	Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05		
21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units)		
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17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

		1.NO0226N20
	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF	F MANAGEMENT OF ANAESTHESIA for fluoroscopy (4 basic units)
21926	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units)
21930	Fee: \$122.40	Benefit: 75% = \$91.80 85% = \$104.05
	INITIATION OF	MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units)
21935	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
		MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time examination (5 basic units)
21024	_	6 of explanatory notes to this Category)
21936	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF units)	MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic
21939	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05
		F MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary ntriculography, cardiac mapping, insertion of automatic defibrillator or transvenous sic units)
21941	(See para TN.10.25 Fee: \$142.80	5 of explanatory notes to this Category) Benefit: 75% = \$107.10 85% = \$121.40
		F MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures requency ablation (10 basic units)
21942	Fee: \$204.00	Benefit: 75% = \$153.00 85% = \$173.40
		F MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of on catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure
21943	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF epidural injection	F MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or in (5 basic units)
21945	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	INITIATION OF of transplantation	MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose (5 basic units)
21949	Fee: \$102.00	Benefit: 75% = \$76.50 85% = \$86.70
	Initiation of the r hyperpyrexia (4 l	nanagement of anaesthesia for diagnostic muscle biopsy to assess for malignant pasic units)
21952	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
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17. ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES

21990	(See para TN.10.12 of explanatory notes to this Category)		
ı	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units)		
	Subgroup 18. Miscellaneous		
	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
ANAEST ONLY PA PERFOR	ATIVE VALUE GUIDE FOR HESIA - MEDICARE BENEFITS ARE AYABLE FOR ANAESTHESIA MED IN ASSOCIATION WITH AN E SERVICE 18. MISCELLANEOUS		
21980	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
21976	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70 INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units)		
21076	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units) From \$102.00. Panefit: 750/ - \$76.50. 850/ - \$86.70.		
21973	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units) Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
21970	Fee: \$306.00 Benefit: 75% = \$229.50 85% = \$260.10 INITIATION OF MANAGEMENT OF ANAESTHESIA for brochythogopy using radioactive scaled		
	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)		
21969	Fee: \$163.20 Benefit: 75% = \$122.40 85% = \$138.75		
	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)		
21965	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	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)		
21962	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units)		
21959	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units)		
21955	Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units)		

18. MISCELLANEOUS

	Fee: \$61.20	Benefit: 75% = \$45.90 85% = \$52.05
		F MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 ion with a procedure covered by an item which has not been identified as attracting an asic units)
21992	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40
	INITIATION OF MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by item that does not include the word "(Anaes.)", other than a service to which item 21965 or 21992 applies, if there is a clinical need for anaesthesia (4 basic units)	
	(See para TN.10.1	3 of explanatory notes to this Category)
21997	Fee: \$81.60	Benefit: 75% = \$61.20 85% = \$69.40

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN

LE SERVICE 19. THERAPEUTIC AND DIAGNOSTIC SERVICES		
Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
Subgroup 19. Therapeutic And Diagnostic Services		
Administration of homologous blood or bone marrow already collected, when performed in association with the management of anaesthesia (4 basic units)		
(See para TN.10.8 of explanatory notes to this Category) Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40		
ENDOTRACHEAL INTUBATION with flexible fibreoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 basic units)		
Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40		
DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER, insertion of when performed in association with the administration of anaesthesia (4 basic units)		
Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40		
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)		
(See para TN.10.8 of explanatory notes to this Category)		
Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05		
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		

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

ELIGIBL	LE SERVICE 19. T	HERAPEUTIC AND DIAGNOSTIC SERVICES
	(b) relating to another discrete operation on the same(c) other than a service to which item 13876 applies(d) who is categorised as having a high risk of compleither complications or a high risk of complications (ications or develops during the current procedure
	(See para TN.10.8 of explanatory notes to this Category) Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$	52.05
	RIGHT HEART BALLOON CATHETER, insertion cardiac output measurement, when performed in assobasic units)	
22015	(See para TN.10.8 of explanatory notes to this Category) Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$	104.05
	CENTRAL VEIN CATHETERISATION by percuta which item 13318 applies, when performed in associunits)	
22020	(See para TN.1.6, TN.10.8 of explanatory notes to this Cat Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$	
	Intra-arterial cannulation when performed in associat who: (a) is categorised as having a high risk of complication (b) develops a high risk of complications during the process of the para TN.10.8 of explanatory notes to this Category)	ons; or procedure (4 basic units)
22025	Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$	69.40
	Intrathecal or epidural injection (initial) of a therapeur insertion of a catheter, in association with anaesthesis not being a service to which 22036 applies (5 basic unit being a service to which 22036 applies).	a and surgery, for post-operative pain management,
22031	(See para TN.10.17 of explanatory notes to this Category) Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$	86.70
	INTRATHECAL or EPIDURAL INJECTION (subsequence of subsequence of subsequence) in association with an answer of subsequence of	sia and surgery, for postoperative pain
22036	(See para TN.10.17 of explanatory notes to this Category) Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$	52.05
	Perioperative introduction of a plexus or nerve block operative pain management (2 basic units) (See para TN.10.17 of explanatory notes to this Category)	proximal to the lower leg or forearm for post
22041	Fee: \$40.80 Benefit: 75% = \$30.60 85% = \$	34.70
	Introduction of a nerve block performed via a retrobucomplex eye block, when administered by an anaesth	-
22042	(See para TN.10.8 of explanatory notes to this Category) Fee: \$20.40 Benefit: 75% = \$15.30 85% = \$	17.35
22051	INTRA-OPERATIVE TRANSOESOPHAGEAL EC	HOCARDIOGRAPHY - Monitoring in real time of

19. THERAPEUTIC AND DIAGNOSTIC SERVICES

	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)
	(See para TN.10.30 of explanatory notes to this Category) Fee: \$183.60 Benefit: 75% = \$137.70 85% = \$156.10
	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (12 basic units)
22055	(See para TN.10.10 of explanatory notes to this Category) Fee: \$244.80 Benefit: 75% = \$183.60 85% = \$208.10
	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 (Anaes.) (30 basic units)
Amend Fee 22060	(See para TN.10.10, TN.10.3 of explanatory notes to this Category) Fee: \$612.00 Benefit: 75% = \$459.00 85% = \$527.30
	INDUCED CONTROLLED HYPOTHERMIA total body, being a service to which item 22060 applies, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (5 basic units)
22065	(See para TN.10.10 of explanatory notes to this Category) Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70
	DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°c, including management of retrograde cerebral perfusion if performed, not being a service associated with anaesthesia to which an item in Subgroup 21 applies (15 basic units)
22075	(See para TN.10.10 of explanatory notes to this Category) Fee: \$306.00 Benefit: 75% = \$229.50 85% = \$260.10

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE

20. ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE

	Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
	Subgroup 20. Administration Of Anaesthesia In Connection With A Dental Service		
	INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (6 basic units)		
22900	(See para TN.10.14 of explanatory notes to this Category) Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05		
	INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (6 basic units)		
22905	(See para TN.10.14 of explanatory notes to this Category) Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05		

LE SERVICE 21. ANAESTHESIA/PERFUSION TIME UNITS		
Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service		
Subgroup 21. Anaesthesia/Perfusion Time Units		
ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA		
(a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or		
(b) perfusion performed in association with item 22060; or		
(c) for assistance at anaesthesia performed in association with items 25200 to 25205		
For a period of:		
(FIFTEEN MINUTES OR LESS) (1 basic units)		
(See para TN.10.3 of explanatory notes to this Category) Fee: \$20.40 Benefit: 75% = \$15.30 85% = \$17.35		
16 MINUTES TO 30 MINUTES (2 basic units)		
Fee: \$40.80 Benefit: 75% = \$30.60 85% = \$34.70		
31 MINUTES to 45 MINUTES (3 basic units)		
Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05		
46 MINUTES to 1:00 HOUR (4 basic units)		
Fee: \$81.60 Benefit: 75% = \$61.20 85% = \$69.40		
1:01 HOURS to 1:15 HOURS (5 basic units)		
Fee: \$102.00 Benefit: 75% = \$76.50 85% = \$86.70		
1:16 HOURS to 1:30 HOURS (6 basic units)		
Fee: \$122.40 Benefit: 75% = \$91.80 85% = \$104.05		
1:31 HOURS to 1:45 HOURS (7 basic units)		
Fee: \$142.80 Benefit: 75% = \$107.10 85% = \$121.40		
1:46 HOURS to 2:00 HOURS (8 basic units)		
Fee: \$163.20 Benefit: 75% = \$122.40 85% = \$138.75		
2:01 HOURS TO 2:10 HOURS (9 basic units)		
Fee: \$183.60 Benefit: 75% = \$137.70 85% = \$156.10		

	2:11 HOURS TO	2:20 HOURS (10 basic units	s)
23101	Fee: \$204.00	Benefit: 75% = \$153.00	85% = \$173.40
	2:21 HOURS TO	2:30 HOURS (11 basic units	s)
23111	Fee: \$224.40	Benefit: 75% = \$168.30	85% = \$190.75
	2:31 HOURS TO	2:40 HOURS (12 basic units	s)
23112	Fee: \$244.80	Benefit: 75% = \$183.60	85% = \$208.10
	2:41 HOURS TO	2:50 HOURS (13 basic units	s)
23113	Fee: \$265.20	Benefit: 75% = \$198.90	85% = \$225.45
	2:51 HOURS TO	3:00 HOURS (14 basic units	s)
23114	Fee: \$285.60	Benefit: 75% = \$214.20	85% = \$242.80
	3:01 HOURS TO	3:10 HOURS (15 basic units	s)
23115	Fee: \$306.00	Benefit: 75% = \$229.50	85% = \$260.10
	3:11 HOURS TO	3:20 HOURS (16 basic units	s)
23116	Fee: \$326.40	Benefit: 75% = \$244.80	85% = \$277.45
	3:21 HOURS TO	3:30 HOURS (17 basic units	8)
23117	Fee: \$346.80	Benefit: 75% = \$260.10	85% = \$294.80
	3:31 HOURS TO	3:40 HOURS (18 basic units	8)
23118	Fee: \$367.20	Benefit: 75% = \$275.40	85% = \$312.15
	3:41 HOURS TO	3:50 HOURS (19 basic units	5)
23119	Fee: \$387.60	Benefit: 75% = \$290.70	85% = \$329.50
	3:51 HOURS TO	0 4:00 HOURS (20 basic units	8)
23121	Fee: \$408.00	Benefit: 75% = \$306.00	85% = \$346.80
	4:01 HOURS TO 4:10 HOURS (21 basic units)		
23170	Fee: \$428.40	Benefit: 75% = \$321.30	85% = \$364.15
	4:11 HOURS TO 4:20 HOURS (22 basic units)		
23180	Fee: \$448.80	Benefit: 75% = \$336.60	85% = \$381.50
	4:21 HOURS TO	0 4:30 HOURS (23 basic units	5)
23190	Fee: \$469.20	Benefit: 75% = \$351.90	85% = \$398.85
	4:31 HOURS TO 4:40 HOURS (24 basic units)		
23200	Fee: \$489.60	Benefit: 75% = \$367.20	85% = \$416.20

LLIGID	LL SLIVICL		21. ANALSTILSIA/FERT USION TIME UNITS
	4:41 HOURS TO 4:50 HOURS (25 basic units)		
23210	Fee: \$510.00	Benefit: 75% = \$382.50	85% = \$433.50
	4:51 HOURS TO	O 5:00 HOURS (26 basic unit	ts)
23220	Fee: \$530.40	Benefit: 75% = \$397.80	85% = \$450.85
	5:01 HOURS TO	O 5:10 HOURS (27 basic unit	ts)
23230	Fee: \$550.80	Benefit: 75% = \$413.10	85% = \$468.20
	5:11 HOURS TO	O 5:20 HOURS (28 basic unit	ts)
23240	Fee: \$571.20	Benefit: 75% = \$428.40	85% = \$486.50
	5:21 HOURS TO	O 5:30 HOURS (29 basic unit	ts)
23250	Fee: \$591.60	Benefit: 75% = \$443.70	85% = \$506.90
	5:31 HOURS TO	O 5:40 HOURS (30 basic unit	ts)
23260	Fee: \$612.00	Benefit: 75% = \$459.00	85% = \$527.30
	5:41 HOURS TO	O 5:50 HOURS (31 basic unit	ts)
23270	Fee: \$632.40	Benefit: 75% = \$474.30	85% = \$547.70
	(5:51 HOURS TO 6:00 HOURS (32 basic units)		
23280	Fee: \$652.80	Benefit: 75% = \$489.60	85% = \$568.10
	6:01 HOURS TO	O 6:10 HOURS (33 basic unit	ts)
23290	Fee: \$673.20	Benefit: 75% = \$504.90	85% = \$588.50
	6:11 HOURS TO	O 6:20 HOURS (34 basic unit	ts)
23300	Fee: \$693.60	Benefit: 75% = \$520.20	85% = \$608.90
	6:21 HOURS TO	O 6:30 HOURS (35 basic unit	ts)
23310	Fee: \$714.00	Benefit: 75% = \$535.50	85% = \$629.30
	6:31 HOURS TO	O 6:40 HOURS (36 basic unit	ts)
23320	Fee: \$734.40	Benefit: 75% = \$550.80	85% = \$649.70
	6:41 HOURS TO 6:50 HOURS (37 basic units)		
23330	Fee: \$754.80	Benefit: 75% = \$566.10	85% = \$670.10
	6:51 HOURS TO	O 7:00 HOURS (38 basic unit	ts)
23340	Fee: \$775.20	Benefit: 75% = \$581.40	85% = \$690.50
	7:01 HOURS TO 7:10 HOURS (39 basic units)		
23350	Fee: \$795.60	Benefit: 75% = \$596.70	85% = \$710.90

LE SERVICE		21. ANALSTILSIA/FLKI USION TIME UNITS
7:11 HOURS TO 7:20 HOURS (40 basic units)		
Fee: \$816.00	Benefit: 75% = \$612.00	85% = \$731.30
7:21 HOURS TO	7:30 HOURS (41 basic uni	ts)
Fee: \$836.40	Benefit: 75% = \$627.30	85% = \$751.70
7:31 HOURS TO	7:40 HOURS (42 basic uni	ts)
Fee: \$856.80	Benefit: 75% = \$642.60	85% = \$772.10
7:41 HOURS TO	7:50 HOURS (43 basic uni	ts)
Fee: \$877.20	Benefit: 75% = \$657.90	85% = \$792.50
7:51 HOURS TO	8:00 HOURS (44 basic uni	ts)
Fee: \$897.60	Benefit: 75% = \$673.20	85% = \$812.90
8:01 HOURS TO	8:10 HOURS (45 basic uni	ts)
Fee: \$918.00	Benefit: 75% = \$688.50	85% = \$833.30
8:11 HOURS TO	8:20 HOURS (46 basic uni	ts)
Fee: \$938.40	Benefit: 75% = \$703.80	85% = \$853.70
8:21 HOURS TO	8:30 HOURS (47 basic uni	ts)
Fee: \$958.80	Benefit: 75% = \$719.10	85% = \$874.10
8:31 HOURS TO	8:40 HOURS (48 basic uni	ts)
Fee: \$979.20	Benefit: 75% = \$734.40	85% = \$894.50
8:41 HOURS TO	8:50 HOURS (49 basic uni	ts)
Fee: \$999.60	Benefit: 75% = \$749.70	85% = \$914.90
8:51 HOURS TO	9:00 HOURS (50 basic uni	ts)
Fee: \$1,020.00	Benefit: 75% = \$765.00	85% = \$935.30
9:01 HOURS TO	9:10 HOURS (51 basic uni	ts)
Fee: \$1,040.40	Benefit: 75% = \$780.30	85% = \$955.70
9:11 HOURS TO 9:20 HOURS (52 basic units)		
Fee: \$1,060.80	Benefit: 75% = \$795.60	85% = \$976.10
9:21 HOURS TO	9:30 HOURS (53 basic uni	ts)
Fee: \$1,081.20	Benefit: 75% = \$810.90	85% = \$996.50
9:31 HOURS TO 9:40 HOURS (54 basic units)		
Fee: \$1,101.60	Benefit: 75% = \$826.20	85% = \$1016.90
	Fee: \$816.00 7:21 HOURS TO Fee: \$836.40 7:31 HOURS TO Fee: \$856.80 7:41 HOURS TO Fee: \$877.20 7:51 HOURS TO Fee: \$897.60 8:01 HOURS TO Fee: \$918.00 8:11 HOURS TO Fee: \$938.40 8:21 HOURS TO Fee: \$958.80 8:31 HOURS TO Fee: \$999.60 8:51 HOURS TO Fee: \$1,020.00 9:01 HOURS TO Fee: \$1,040.40 9:11 HOURS TO Fee: \$1,040.40 9:11 HOURS TO Fee: \$1,040.40 9:21 HOURS TO Fee: \$1,040.40 9:21 HOURS TO Fee: \$1,040.40 9:31 HOURS TO	7:11 HOURS TO 7:20 HOURS (40 basic unifee: \$816.00 7:21 HOURS TO 7:30 HOURS (41 basic unifee: \$836.40 7:31 HOURS TO 7:40 HOURS (42 basic unifee: \$856.80 8enefit: 75% = \$642.60 7:41 HOURS TO 7:50 HOURS (43 basic unifee: \$877.20 8:01 HOURS TO 8:00 HOURS (44 basic unifee: \$897.60 8:01 HOURS TO 8:10 HOURS (45 basic unifee: \$918.00 8:11 HOURS TO 8:20 HOURS (46 basic unifee: \$938.40 8:21 HOURS TO 8:30 HOURS (47 basic unifee: \$958.80 8:31 HOURS TO 8:40 HOURS (48 basic unifee: \$999.60 8:41 HOURS TO 8:50 HOURS (48 basic unifee: \$999.60 8:41 HOURS TO 8:50 HOURS (45 basic unifee: \$999.60 8:51 HOURS TO 9:00 HOURS (50 basic unifee: \$901 HOURS TO 9:00 HOURS (51 basic unifee: \$1,020.00 9:01 HOURS TO 9:20 HOURS (52 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:11 HOURS TO 9:30 HOURS (53 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:11 HOURS TO 9:30 HOURS (54 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:11 HOURS TO 9:30 HOURS (53 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:11 HOURS TO 9:30 HOURS (54 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:31 HOURS TO 9:40 HOURS (54 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:31 HOURS TO 9:40 HOURS (54 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:31 HOURS TO 9:40 HOURS (54 basic unifee: \$1,040.40 8enefit: 75% = \$780.30 9:31 HOURS TO 9:40 HOURS (54 basic unifee: \$1,040.40

	LE SERVICE		21. ANAEST HESIA/PERFUSION TIME UNITS	
	9:41 HOURS TO 9:50 HOURS (55 basic units)			
23510	Fee: \$1,122.00	Benefit: 75% = \$841.50	85% = \$1037.30	
	9:51 HOURS TO	10:00 HOURS (56 basic un	uits)	
23520	Fee: \$1,142.40	Benefit: 75% = \$856.80	85% = \$1057.70	
	10:01 HOURS TO	0 10:10 HOURS (57 basic u	units)	
23530	Fee: \$1,162.80	Benefit: 75% = \$872.10	85% = \$1078.10	
	10:11 HOURS TO	0 10:20 HOURS (58 basic u	units)	
23540	Fee: \$1,183.20	Benefit: 75% = \$887.40	85% = \$1098.50	
	10:21 HOURS TO	0 10:30 HOURS (59 basic u	units)	
23550	Fee: \$1,203.60	Benefit: 75% = \$902.70	85% = \$1118.90	
	10:31 HOURS TO	0 10:40 HOURS (60 basic u	units)	
23560	Fee: \$1,224.00	Benefit: 75% = \$918.00	85% = \$1139.30	
	10:41 HOURS TO	0 10:50 HOURS (61 basic u	units)	
23570	Fee: \$1,244.40	Benefit: 75% = \$933.30	85% = \$1159.70	
	10:51 HOURS TO 11:00 HOURS (62 basic units)			
23580	Fee: \$1,264.80	Benefit: 75% = \$948.60	85% = \$1180.10	
	11:01 HOURS TO	D 11:10 HOURS (63 basic u	units)	
23590	Fee: \$1,285.20	Benefit: 75% = \$963.90	85% = \$1200.50	
	11:11 HOURS TO	D 11:20 HOURS (64 basic u	units)	
23600	Fee: \$1,305.60	Benefit: 75% = \$979.20	85% = \$1220.90	
	11:21 HOURS TO	D 11:30 HOURS (65 basic u	inits)	
23610	Fee: \$1,326.00	Benefit: 75% = \$994.50	85% = \$1241.30	
	11:31 HOURS TO	D 11:40 HOURS (66 basic u	units)	
23620	Fee: \$1,346.40	Benefit: 75% = \$1009.80	85% = \$1261.70	
	11:41 HOURS TO	D 11:50 HOURS (67 basic u	units)	
23630	Fee: \$1,366.80	Benefit: 75% = \$1025.10	85% = \$1282.10	
	11:51 HOURS TO	D 12:00 HOURS (68 basic u	units)	
23640	Fee: \$1,387.20	Benefit: 75% = \$1040.40	85% = \$1302.50	
	12:01 HOURS TO	D 12:10 HOURS (69 basic u	units)	
23650	Fee: \$1,407.60	Benefit: 75% = \$1055.70	85% = \$1322.90	

LLIGIB	LL SLIVICL		21. ANALSTITESIA/FERT USION TIME UNITS
	12:11 HOURS TO	O 12:20 HOURS (70 basic ur	nits)
23660	Fee: \$1,428.00	Benefit: 75% = \$1071.00	85% = \$1343.30
	12:21 HOURS TO	D 12:30 HOURS (71 basic ur	nits)
23670	Fee: \$1,448.40	Benefit: 75% = \$1086.30	85% = \$1363.70
	12:31 HOURS TO	D 12:40 HOURS (72 basic ur	nits)
23680	Fee: \$1,468.80	Benefit: 75% = \$1101.60	85% = \$1384.10
	12:41 HOURS TO	D 12:50 HOURS (73 basic ur	aits)
23690	Fee: \$1,489.20	Benefit: 75% = \$1116.90	85% = \$1404.50
	12:51 HOURS TO	D 13:00 HOURS (74 basic ur	aits)
23700	Fee: \$1,509.60	Benefit: 75% = \$1132.20	85% = \$1424.90
	13:01 HOURS TO	D 13:10 HOURS (75 basic ur	aits)
23710	Fee: \$1,530.00	Benefit: 75% = \$1147.50	85% = \$1445.30
	13:11 HOURS TO	O 13:20 HOURS (76 basic ur	aits)
23720	Fee: \$1,550.40	Benefit: 75% = \$1162.80	85% = \$1465.70
	13:21 HOURS TO	O 13:30 HOURS (77 basic ur	nits)
23730	Fee: \$1,570.80	Benefit: 75% = \$1178.10	85% = \$1486.10
	13:31 HOURS TO	D 13:40 HOURS (78 basic ur	nits)
23740	Fee: \$1,591.20	Benefit: 75% = \$1193.40	85% = \$1506.50
	13:41 HOURS TO	0 13:50 HOURS (79 basic ur	nits)
23750	Fee: \$1,611.60	Benefit: 75% = \$1208.70	85% = \$1526.90
	13:51 HOURS TO	0 14:00 HOURS (80 basic ur	nits)
23760	Fee: \$1,632.00	Benefit: 75% = \$1224.00	85% = \$1547.30
	14:01 HOURS TO	D 14:10 HOURS (81 basic ur	nits)
23770	Fee: \$1,652.40	Benefit: 75% = \$1239.30	85% = \$1567.70
	14:11 HOURS TO	O 14:20 HOURS (82 basic ur	nits)
23780	Fee: \$1,672.80	Benefit: 75% = \$1254.60	85% = \$1588.10
	14:21 HOURS TO	D 14:30 HOURS (83 basic ur	nits)
23790	Fee: \$1,693.20	Benefit: 75% = \$1269.90	85% = \$1608.50
	14:31 HOURS TO	O 14:40 HOURS (84 basic ur	nits)
23800	Fee: \$1,713.60	Benefit: 75% = \$1285.20	85% = \$1628.90

LL OLIVIOL		21. ANALSTITESIA/FERT USION TIME UNITS
14:41 HOURS TO) 14:50 HOURS (85 basic ur	nits)
Fee: \$1,734.00	Benefit: 75% = \$1300.50	85% = \$1649.30
14:51 HOURS TO) 15:00 HOURS (86 basic ur	nits)
Fee: \$1,754.40	Benefit: 75% = \$1315.80	85% = \$1669.70
15:01 HOURS TO) 15:10 HOURS (87 basic ur	nits)
Fee: \$1,774.80	Benefit: 75% = \$1331.10	85% = \$1690.10
15:11 HOURS TO) 15:20 HOURS (88 basic ur	nits)
Fee: \$1,795.20	Benefit: 75% = \$1346.40	85% = \$1710.50
15:21 HOURS TO) 15:30 HOURS (89 basic ur	nits)
Fee: \$1,815.60	Benefit: 75% = \$1361.70	85% = \$1730.90
15:31 HOURS TO) 15:40 HOURS (90 basic ur	nits)
Fee: \$1,836.00	Benefit: 75% = \$1377.00	85% = \$1751.30
15:41 HOURS TO) 15:50 HOURS (91 basic ui	nits)
Fee: \$1,856.40	Benefit: 75% = \$1392.30	85% = \$1771.70
15:51 HOURS TO) 16:00 HOURS (92 basic ur	nits)
Fee: \$1,876.80	Benefit: 75% = \$1407.60	85% = \$1792.10
16:01 HOURS TO) 16:10 HOURS (93 basic ur	nits)
Fee: \$1,897.20	Benefit: 75% = \$1422.90	85% = \$1812.50
16:11 HOURS TO) 16:20 HOURS (94 basic ur	nits)
Fee: \$1,917.60	Benefit: 75% = \$1438.20	85% = \$1832.90
16:21 HOURS TO) 16:30 HOURS (95 basic ur	nits)
Fee: \$1,938.00	Benefit: 75% = \$1453.50	85% = \$1853.30
16:31 HOURS TO) 16:40 HOURS (96 basic ur	nits)
Fee: \$1,958.40	Benefit: 75% = \$1468.80	85% = \$1873.70
16:41 HOURS TO) 16:50 HOURS (97 basic ur	nits)
Fee: \$1,978.80	Benefit: 75% = \$1484.10	85% = \$1894.10
16:51 HOURS TO	0 17:00 HOURS (98 basic ur	nits)
Fee: \$1,999.20	Benefit: 75% = \$1499.40	85% = \$1914.50
17:01 HOURS TO) 17:10 HOURS (99 basic ur	nits)
Fee: \$2,019.60	Benefit: 75% = \$1514.70	85% = \$1934.90
	Fee: \$1,734.00 14:51 HOURS TO Fee: \$1,754.40 15:01 HOURS TO Fee: \$1,774.80 15:11 HOURS TO Fee: \$1,795.20 15:21 HOURS TO Fee: \$1,815.60 15:31 HOURS TO Fee: \$1,836.00 15:41 HOURS TO Fee: \$1,856.40 15:51 HOURS TO Fee: \$1,876.80 16:01 HOURS TO Fee: \$1,876.80 16:11 HOURS TO Fee: \$1,997.20 16:31 HOURS TO Fee: \$1,917.60 16:21 HOURS TO Fee: \$1,938.00 16:31 HOURS TO Fee: \$1,938.00 16:31 HOURS TO Fee: \$1,938.00 16:31 HOURS TO Fee: \$1,938.00 16:41 HOURS TO Fee: \$1,958.40 16:51 HOURS TO Fee: \$1,978.80 16:51 HOURS TO Fee: \$1,978.80 16:51 HOURS TO Fee: \$1,999.20 17:01 HOURS TO	14:41 HOURS TO 14:50 HOURS (85 basic un Fee: \$1,734.00

LLIGIB	LL SLIVICL		21. ANALSTITESIA/FERT USION TIME UNITS
	17:11 HOURS TO	17:20 HOURS (100 basic u	units)
23960	Fee: \$2,040.00	Benefit: 75% = \$1530.00	85% = \$1955.30
	17:21 HOURS TO	17:30 HOURS (101 basic u	units)
23970	Fee: \$2,060.40	Benefit: 75% = \$1545.30	85% = \$1975.70
	17:31 HOURS TO	17:40 HOURS (102 basic u	units)
23980	Fee: \$2,080.80	Benefit: 75% = \$1560.60	85% = \$1996.10
	17:41 HOURS TO	17:50 HOURS (103 basic u	units)
23990	Fee: \$2,101.20	Benefit: 75% = \$1575.90	85% = \$2016.50
	17:51 HOURS TO	18:00 HOURS (104 basic u	units)
24100	Fee: \$2,121.60	Benefit: 75% = \$1591.20	85% = \$2036.90
	18:01 HOURS TO	18:10 HOURS (105 basic u	units)
24101	Fee: \$2,142.00	Benefit: 75% = \$1606.50	85% = \$2057.30
	18:11 HOURS TO	18:20 HOURS (106 basic u	units)
24102	Fee: \$2,162.40	Benefit: 75% = \$1621.80	85% = \$2077.70
	18:21 HOURS TO	18:30 HOURS (107 basic u	units)
24103	Fee: \$2,182.80	Benefit: 75% = \$1637.10	85% = \$2098.10
	18:31 HOURS TO	18:40 HOURS (108 basic u	units)
24104	Fee: \$2,203.20	Benefit: 75% = \$1652.40	85% = \$2118.50
	18:41 HOURS TO	18:50 HOURS (109 basic u	units)
24105	Fee: \$2,223.60	Benefit: 75% = \$1667.70	85% = \$2138.90
	18:51 HOURS TO	19:00 HOURS (110 basic u	units)
24106	Fee: \$2,244.00	Benefit: 75% = \$1683.00	85% = \$2159.30
	19:01 HOURS TO	0 19:10 HOURS (111 basic u	units)
24107	Fee: \$2,264.40	Benefit: 75% = \$1698.30	85% = \$2179.70
	19:11 HOURS TO	19:20 HOURS (112 basic u	units)
24108	Fee: \$2,284.80	Benefit: 75% = \$1713.60	85% = \$2200.10
	19:21 HOURS TO	19:30 HOURS (113 basic u	units)
24109	Fee: \$2,305.20	Benefit: 75% = \$1728.90	85% = \$2220.50
	19:31 HOURS TO	19:40 HOURS (114 basic ι	units)
24110	Fee: \$2,325.60	Benefit: 75% = \$1744.20	85% = \$2240.90

LLIGID	LL SLIVICL		21. ANALSTITESIA/FERT USION TIME UNITS
	19:41 HOURS T	O 19:50 HOURS (115 basic t	units)
24111	Fee: \$2,346.00	Benefit: 75% = \$1759.50	85% = \$2261.30
	19:51 HOURS T	O 20:00 HOURS (116 basic 1	units)
24112	Fee: \$2,366.40	Benefit: 75% = \$1774.80	85% = \$2281.70
	20:01 HOURS T	O 20:10 HOURS (117 basic u	units)
24113	Fee: \$2,386.80	Benefit: 75% = \$1790.10	85% = \$2302.10
	20:11 HOURS T	O 20:20 HOURS (118 basic u	units)
24114	Fee: \$2,407.20	Benefit: 75% = \$1805.40	85% = \$2322.50
	20:21 HOURS T	O 20:30 HOURS (119 basic u	units)
24115	Fee: \$2,427.60	Benefit: 75% = \$1820.70	85% = \$2342.90
	20:31 HOURS T	O 20:40 HOURS (120 basic ι	units)
24116	Fee: \$2,448.00	Benefit: 75% = \$1836.00	85% = \$2363.30
	20:41 HOURS T	O 20:50 HOURS (121 basic t	units)
24117	Fee: \$2,468.40	Benefit: 75% = \$1851.30	85% = \$2383.70
	20:51 HOURS T	O 21:00 HOURS (122 basic u	units)
24118	Fee: \$2,488.80	Benefit: 75% = \$1866.60	85% = \$2404.10
	21:01 HOURS T	O 21:10 HOURS (123 basic u	units)
24119	Fee: \$2,509.20	Benefit: 75% = \$1881.90	85% = \$2424.50
	21:11 HOURS T	O 21:20 HOURS (124 basic t	units)
24120	Fee: \$2,529.60	Benefit: 75% = \$1897.20	85% = \$2444.90
	21:21 HOURS T	O 21:30 HOURS (125 basic t	units)
24121	Fee: \$2,550.00	Benefit: 75% = \$1912.50	85% = \$2465.30
	21:31 HOURS T	O 21:40 HOURS (126 basic u	units)
24122	Fee: \$2,570.40	Benefit: 75% = \$1927.80	85% = \$2485.70
	21:41 HOURS T	O 21:50 HOURS (127 basic u	units)
24123	Fee: \$2,590.80	Benefit: 75% = \$1943.10	85% = \$2506.10
	21:51 HOURS T	O 22:00 HOURS (128 basic u	units)
24124	Fee: \$2,611.20	Benefit: 75% = \$1958.40	85% = \$2526.50
	22:01 HOURS T	O 22:10 HOURS (129 basic u	units)
24125	Fee: \$2,631.60	Benefit: 75% = \$1973.70	85% = \$2546.90

21. ANAESTHESIA/PERFUSION TIME UNITS

	22:11 HOURS TO	22:20 HOURS (130 basic u	units)
24126	Fee: \$2,652.00	Benefit: 75% = \$1989.00	85% = \$2567.30
	22:21 HOURS TO	22:30 HOURS (131 basic u	units)
24127	Fee: \$2,672.40	Benefit: 75% = \$2004.30	85% = \$2587.70
	22:31 HOURS TO	22:40 HOURS (132 basic t	units)
24128	Fee: \$2,692.80	Benefit: 75% = \$2019.60	85% = \$2608.10
	22:41 HOURS TO	22:50 HOURS (133 basic t	units)
24129	Fee: \$2,713.20	Benefit: 75% = \$2034.90	85% = \$2628.50
	22:51 HOURS TO	23:00 HOURS (134 basic t	units)
24130	Fee: \$2,733.60	Benefit: 75% = \$2050.20	85% = \$2648.90
	23:01 HOURS TO	23:10 HOURS (135 basic t	units)
24131	Fee: \$2,754.00	Benefit: 75% = \$2065.50	85% = \$2669.30
	23:11 HOURS TO	23:20 HOURS (136 basic t	units)
24132	Fee: \$2,774.40	Benefit: 75% = \$2080.80	85% = \$2689.70
	23:21 HOURS TO	23:30 HOURS (137 basic u	units)
24133	Fee: \$2,794.80	Benefit: 75% = \$2096.10	85% = \$2710.10
	23:31 HOURS TO	23:40 HOURS (138 basic u	units)
24134	Fee: \$2,815.20	Benefit: 75% = \$2111.40	85% = \$2730.50
	23:41 HOURS TO	23:50 HOURS (139 basic u	inits)
24135	Fee: \$2,835.60	Benefit: 75% = \$2126.70	85% = \$2750.90
	23:51 HOURS TO	24:00 HOURS (140 basic t	units)
24136	Fee: \$2,856.00	Benefit: 75% = \$2142.00	85% = \$2771.30

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN 22. ANAESTHESIA/PERFUSION MODIFYING **ELIGIBLE 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		
25000	(a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to		

22. ANAESTHESIA/PERFUSION MODIFYING **UNITS - PHYSICAL STATUS**

	22905; or
	(b) for perfusion performed in association with item 22060; or
	(c) for assistance at anaesthesia performed in association with items 25200 to 25205
	Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 basic units)
	(See para TN.10.3 of explanatory notes to this Category) Fee: \$20.40 Benefit: 75% = \$15.30 85% = \$17.35
	Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 basic units)
25005	(See para TN.10.3 of explanatory notes to this Category) Fee: \$40.80 Benefit: 75% = \$30.60 85% = \$34.70
	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 basic units)
25010	(See para TN.10.3 of explanatory notes to this Category) Fee: \$61.20 Benefit: 75% = \$45.90 85% = \$52.05

T10. RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN 23. ANAESTHESIA/PERFUSION MODIFYING **ELIGIBLE SERVICE**

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 aged under 4 years (Anaes.) (1 basic units)	
Fee: \$20.40 Benefit: 75% = \$15.30 85% = \$17.35	
Anaesthesia, perfusion or assistance in the management of anaesthesia, if the patient is aged 75 years or more (Anaes.) (1 basic units)	
Fee: \$20.40 Benefit: 75% = \$15.30 85% = \$17.35	
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) Fee: \$40.80 Benefit: 75% = \$30.60 85% = \$34.70	

24. ANAESTHESIA 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 24. Anaesthesia After Hours Emergency Modifier
	Anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday (0 basic units)
25025	(See para TN.10.3 of explanatory notes to this Category) Derived Fee: An additional amount of 50% of fee for the anaesthetic service. That is:(a) an anaesthesia item/s range 20100 - 21997 or 22900, plus (b)an item range 23010 - 24136, plus(c) if applicable, an item range 25000-25014, plus(d) where performed, any assoc therapeutic or diagnostic service range 22002-22051
	Assistance in the management of anaesthesia, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekday, or on a Saturday, Sunday or public holiday
	(0 basic units)
	(See para TN.10.3 of explanatory notes to this Category)
ANAES	Derived Fee: 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (c) where performed, any associated therapeutic or diagnostic service 22002 -22051 ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE
T10. RE ANAES ONLY F PERFO	25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (c) where performed, any associated therapeutic or diagnostic service 22002 -22051 ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENCY MODIFIE
T10. RE ANAES ONLY F PERFO	25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (c) where performed, any associated therapeutic or diagnostic service 22002 -22051 ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENCE
T10. RE ANAES ONLY F PERFO	25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (c) where performed, any associated therapeutic or diagnostic service 22002 -22051 ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENCY MODIFIE Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For
T10. RE ANAES ONLY F PERFO	25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (c) where performed, any associated therapeutic or diagnostic service 22002 -22051 ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENC MODIFIE Group T10. Relative Value Guide For Anaesthesia - Medicare Benefits Are Only Payable For Anaesthesia Performed In Association With An Eligible Service
T10. RE ANAES ONLY F PERFO ELIGIB	25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (c) where performed, any associated therapeutic or diagnostic service 22002 -22051 ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENC MODIFIE 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 Perfusion, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekda
T10. RE ANAES ONLY F PERFO ELIGIB 25050 T10. RE ANAES ONLY F	25200 - 25205, plus (b) an item range 23010-24136, plus (c) where applicable, an item range 25000-25014, plus (c) where performed, any associated therapeutic or diagnostic service 22002 -22051 ELATIVE VALUE GUIDE FOR THESIA - MEDICARE BENEFITS ARE PAYABLE FOR ANAESTHESIA RMED IN ASSOCIATION WITH AN 25. PERFUSION AFTER HOURS EMERGENC LE SERVICE 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 Perfusion, if the patient requires immediate treatment without which there would be significant threat to life or body part and if more than 50% of the service time occurs between 8 pm to 8 am on any weekda or on a Saturday, Sunday or public holiday. (0 basic units) (See para TN.10.3 of explanatory notes to this Category) Derived Fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060, plus (b) an item range 23010 - 24136, plus (c) where applicable, an item range 25000 - 25014, plus (d) where performed,

26. ASSISTANCE AT ANAESTHESIA

ELIGIBI	LE SERVICE 26. ASSISTANCE AT ANAESTHESIA
	Subgroup 26. Assistance At Anaesthesia
	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units)
25200	(See para TN.10.9 of explanatory notes to this Category) Derived Fee: An amount of \$102.00 (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) Derived Fee: An amount of \$102.00 (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. BC	OTULINUM TOXIN INJECTIONS
	Group T11. Botulinum Toxin Injections
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of hemifacial spasm in a patient who is at least 12 years of age, including all such injections on any one day
18350	(See para TN.11.1 of explanatory notes to this Category) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	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) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	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) Fee: \$257.55 Benefit: 75% = \$193.20 85% = \$218.95

T11 BC	OTULINUM TOXIN INJECTIONS
	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 patient, if:
	(a) the patient is at least 2 years of age; and
	(b) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each lower limb), including all injections per set (Anaes.)
18354	(See para TN.11.1 of explanatory notes to this Category) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	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) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	Clostridium Botulinum Type A Toxin-Haemagglutinin Complex (Dysport) or 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) the treatment is for all or any of the muscles subserving one functional activity and supplied by one motor nerve, with a maximum of 4 sets of injections for the patient on any one day (with a maximum of 2 sets of injections for each upper limb), including all injections per set (Anaes.)
18361	(See para TN.11.1 of explanatory notes to this Category) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	Botulinum Toxin type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of severe primary axillary hyperhidrosis, including all injections on any one day, if:
	(a) the patient is at least 12 years of age; and
	(b) the patient has been intolerant of, or has not responded to, topical aluminium chloride hexahydrate; and
18362	

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) Fee: \$254.40 Benefit: 75% = \$190.80 85% = \$216.25
	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 an acute event, 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
18365	(See para TN.11.1 of explanatory notes to this Category) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of strabismus, including all such injections on any one day and associated electromyography (Anaes.)
18366	(See para TN.11.1 of explanatory notes to this Category) Fee: \$161.30 Benefit: 75% = \$121.00 85% = \$137.15
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of spasmodic dysphonia, including all such injections on any one day
18368	(See para TN.11.1 of explanatory notes to this Category) Fee: \$275.35 Benefit: 75% = \$206.55 85% = \$234.05
	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) Fee: \$46.45 Benefit: 75% = \$34.85 85% = \$39.50
	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of unilateral blepharospasm in a patient who is at least 12 years of age, including all such injections on any one day (Anaes.)
18370	(See para TN.11.1 of explanatory notes to this Category) Fee: \$46.45 Benefit: 75% = \$34.85 85% = \$39.50
18372	Botulinum Toxin Type A Purified Neurotoxin Complex (Botox), injection of, for the treatment of

T11. BO	TULINUM TOXIN INJECTIONS
	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) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	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) Fee: \$128.75 Benefit: 75% = \$96.60 85% = \$109.45
	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: \$237.05 **Benefit:** 75% = \$177.80 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% = \$96.60 85% = \$109.45 18377 Fee: \$128.75 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: \$237.05 **Benefit:** 75% = \$177.80

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